OCTOBER, 1938

THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·

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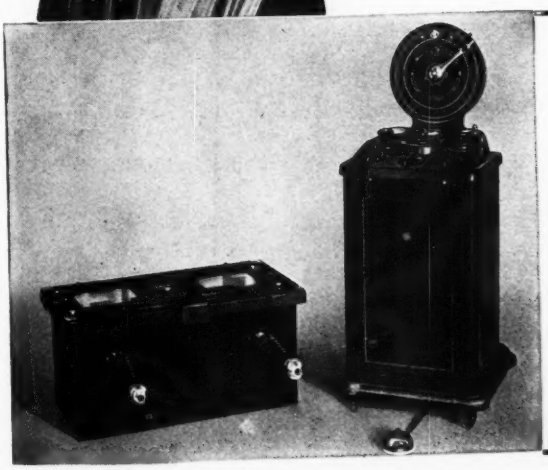

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"The Canadian Hospital"

Official Journal of the
Canadian Hospital Council

CONTENTS

Vol. 15 OCTOBER, 1938 No. 10

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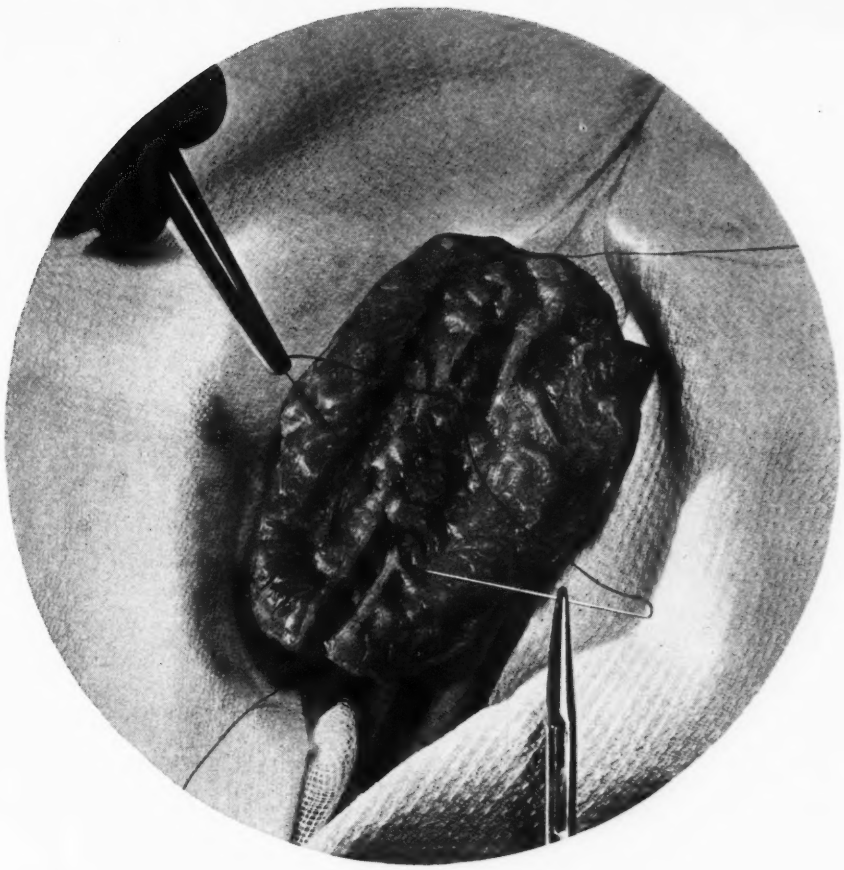

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

I. Cleansing Operations

● As reference to a recent text on canning will disclose (1) the details of commercial canning procedures will vary from product to product. There are, however, certain basic operations which are included in practically all canning procedures. In the belief that they may prove of interest, it is our intention to describe in broad detail the nature and purposes of these essential operations.

One of the first and most important steps in commercial canning is the thorough cleansing of the raw food material received at the cannery. The purpose of such an operation is, of course, immediately evident, namely, to remove soil, dirt or other inedible substances which may be present. However, cleaning also serves to reduce substantially the load of spoilage bacteria with which Nature usually endows raw foods.

Commercially, cleansing is effected in a variety of ways. In general, however, water washers specifically designed for the various types of products are used. In these machines, the raw food material is subjected to high-pressure sprays or strong flowing streams of potable water while passing along a moving belt or while being tumbled by agitating or revolving screens. Sometimes a "flotation" type of washer is also used to remove chaff or similar material. With certain products, water washing is preceded by a "dry" cleaning treatment in which adhering soil and dirt is mechanically removed from the food by revolving or agitating screens, or by strong air-blasts. Also, in certain canning procedures, operations whose basic functions are not primarily to clean the raw material may also exert a cleansing effect. Thus, the "blanch" or scalding treatment accorded many products serves to clean the food, as does the water spray sometimes applied to foods after the blanch.

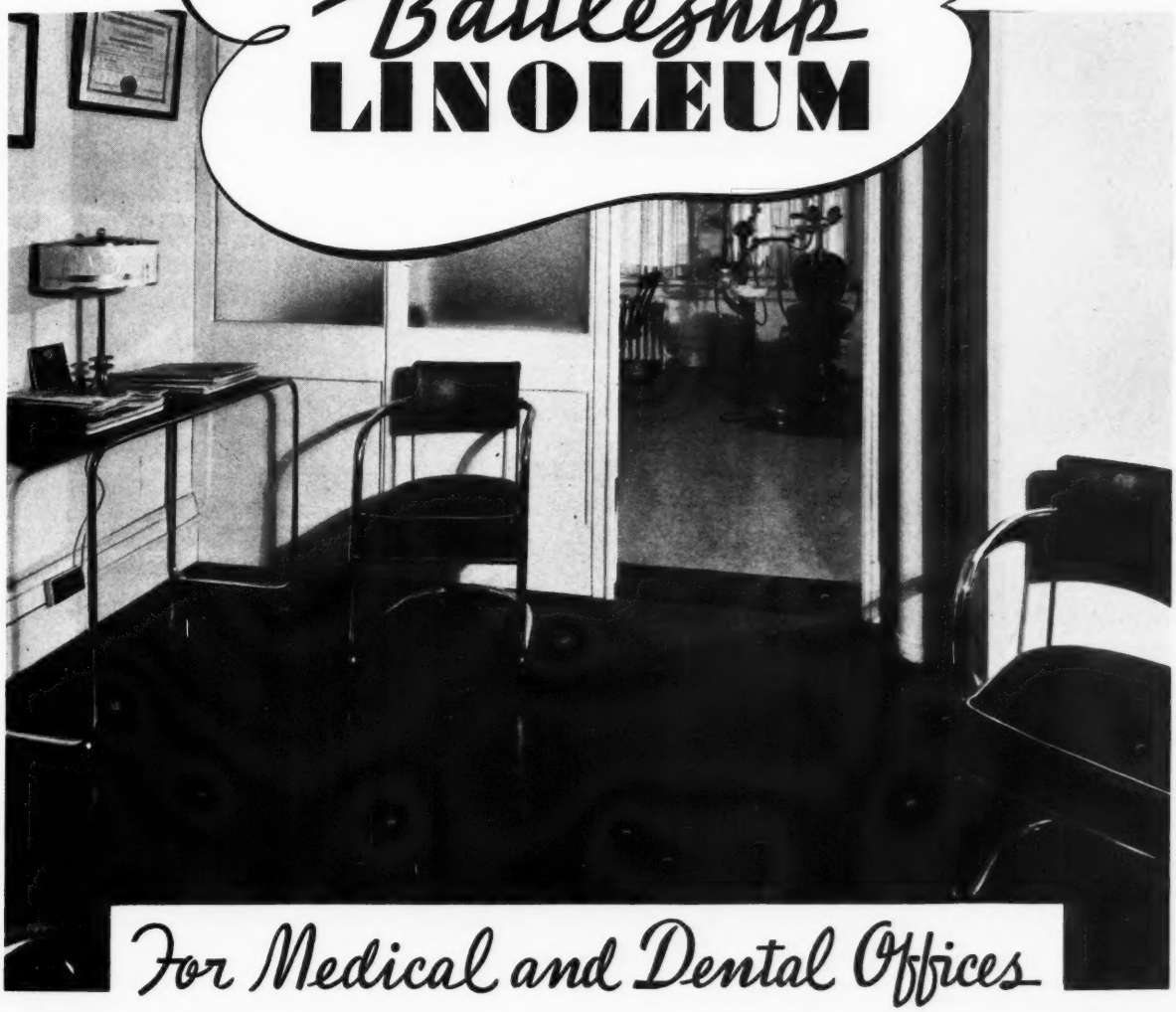
Modern canners know the necessity of thorough cleansing of the raw materials they use. They appreciate that thorough cleaning and removal of extraneous material decreases the load of spoilage organisms which must be destroyed by the heat processes to which all canned foods are subjected. They also appreciate the necessity of maintaining strict plant and equipment sanitation to destroy spoilage bacteria which may be carried in by raw foods.

Because of the efficient cleansing of raw materials and close attention to the other important operations in the commercial canning procedures, modern canned foods must be ranked among the most wholesome foods coming to the Canadian table. (2)

(1) 1937 Appertizing or The Art of Canning, A. W. Bitting, The Trade Pressroom, San Francisco.

(2) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century Co., New York.

DOMINION *Battleship* LINOLEUM



For Medical and Dental Offices

Floors that are sanitary and quiet are just as essential in the private office of doctor and dentist as in the hospital. Permanent floors of Dominion Battleship Linoleum or Marboleum absorb noise and echo of shuffling feet. They provide clean, germicidal floors---for germs cannot live on Linoleum or Marboleum. Available in a wide range of fine colours, designs and effects, they are permanent, easy-to-clean, and require but little attention and no costly repairs or refinishing. Ask your architect or flooring contractor about our five year guarantee.

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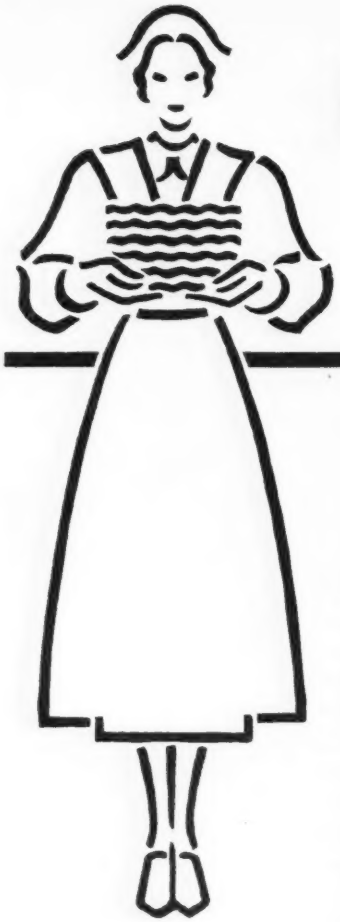

HOSPITAL DRESSINGS SIMPLIFICATION

A MODERN MOVEMENT . . .

Hospital associations, and hospitals individually, are giving greater consideration than ever before to the question of hospital dressings simplification and standardization. The conviction is rapidly growing unanimous that the dressings procedures of hospitals, which have developed over a period of years without much plan or system, have been outmoded. There is need for simplification, elimination of waste —both of time and materials— and for unification of technique.

The use of Ready Made Dressings quickly accomplishes all of these aims. And, almost without exception, it is now actually more economical to buy dressings ready made than to manufacture them in the hospital.

Curity Ready Made Dressings (produced by the originators of the Ready Made Dressings Idea) have been developed with a full and complete understanding of hospital requirements. They comply with the American College of Surgeons specifications and recommendations. They offer you the most direct path to maximum dressings simplification, efficiency and economy.

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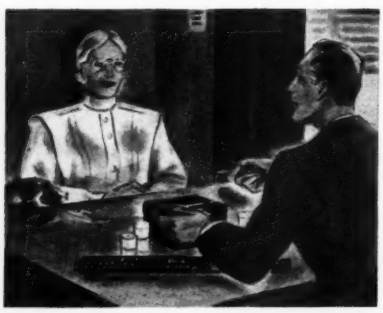
Through his own experience and the national experience of his company, the Curity representative who calls on you is qualified to help you modernize your dressings technique. He is authorized to give unselfishly of his time and knowledge to assist you in your dressings problems. Enlist his aid, without obligation.



Many superintendents and hospital heads have welcomed the suggestion that they arrange a meeting of the Curity representative and those individuals in their hospital most concerned with dressings procedure. A survey of dressings practice by such a group often results in the discovery of ways to improve standards, increase efficiency, cut costs.

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READY MADE DRESSINGS

Harvey Agnew, M.D.,
Editor

The CANADIAN HOSPITAL

October, 1938 Vol. 15 No. 10

ETHICS and MEDICINE

Canadian Medicine brings its Code of Ethics up to date

By ROSS B. MITCHELL, B.A., M.D., C.M. (Man.), F.A.C.S., F.R.C.P. (C)

Associate Professor of Obstetrics, University of Manitoba, Chairman, Committee on Credentials and Ethics, Canadian Medical Association, Winnipeg

THE Canadian Medical Association at the Annual Meeting in Halifax in June adopted a new Code of Ethics which is much more than a revision of the old code. Owing to the increased complexity of modern life and its quickened tempo the old code was found to be no longer sufficient nor always applicable. Dr. Percival of Manchester wrote the old code over a hundred years ago, and with various tinkerings it has lasted down to to-day. But the good doctor wrote it in the days of gigs and saddlebags, and before such marvels as the telephone, the automobile, and radio were even dreamed of. The new code is geared to meet the speed of the present day, but it is also based on principles which have stood the test of time.

The new code was written chiefly by the late Dr. D. A. Stewart, Superintendent of the Manitoba Sanatorium, and for nearly three years Chairman of the Committee on Credentials and Ethics of the Canadian Medical Association. He worked on it up to a few days before his death. As a hospital superintendent he was particularly qualified to treat such topics as "The Relation of Physicians in and with Hospitals", "Nurses and Nursing" and "The Duties of the Profession to the Public". As one who loved his fellowmen, he considered that the chief end of the physician was not to glorify his profession and to enjoy the fruits of his labours, but to embody in his practice Saint Paul's ideal of charity and the spirit of service set forth in the Oath of Hippocrates and in the less familiar but beautiful Prayer of Maimonides.

Much in the new Code of Ethics is directly applicable to medical practice in hospitals.

The Code is not a code in the legal sense; rather it is a code of honour. It is not a collection of laws for the disciplining of erring practitioners, but it is an exposition of the prevalent morality of the medical profession. It opens with the Golden Rule of the Sermon of the Mount and ends with the Oath of the Greek Father of Medicine, 400 B.C., and the Prayer of a Spanish Jew in the Middle Ages.

In the introductory paragraph the Code states: "A code cannot change a low-grade man into a high-grade doctor, but it can help a good man to be a better man and a more enlightened doctor. Only in a few things can it decree "thou shalt" or "thou shalt not", but in many things it can urge "thou shouldst" or "thou shouldst not".

Consultations

One of the first paragraphs deals with consultations. So important is the duty of consultation in difficult cases that much space is devoted to it:

> "It is the duty of the attending physician to accept the opportunity of a second opinion in any illness that is serious, obscure or difficult, or when consultation is desired by the patient or by persons authorized to act on the patient's behalf. While the physician should name the consultant he prefers, he should not refuse to meet the physician of the patient's choice, though he may urge, if he so thinks, that such consultant has not the qualifications or experience that the existing situation demands.

In the following circumstances it is particularly desirable that the attending physician, while dealing with an emergency when this exists, should whenever possible, secure consultation with a colleague:

(a) When the propriety of performing an operation or of adopting a course of treatment which may entail considerable risk to the life, activities or capacities of the patient has to be considered, and particularly when the condition which it is sought to relieve by this treatment is in itself not dangerous to life.

(b) When operative measures involving the death of the foetus or of an unborn child are contemplated, particularly if labour has not begun.

(c) When the propriety of prescribing, or repeating a prescription for, any drug scheduled under the Opium and Narcotic Drug Act, in the case of a person seeking relief from the symptoms of addiction to that drug, is under consideration.

(d) When there are grounds for suspecting that the patient

(I) has been subjected to an illegal operation, or

(ii) is the victim of criminal poisoning.

ROSS B. MITCHELL, M.D.

Consultation is intended primarily for the good of the sick person, since it involves a review of the whole case and a fresh point of view, but it has other advantages. It lightens the burden of the attending physician and of the hospital superintendent if the patient is being treated in an institution. The Canadian Medical Protective Association, organized to protect its members from unjust accusations of malpractice, states that valuable protection is afforded by consultation in all doubtful cases. Hospital superintendents should tactfully suggest the holding of consultations in difficult or obscure cases.

In connection with consultation the Code goes on:

> "If it is impossible for the attending physician and the consultant to make their examinations at the same time, the consultant's conduct must be especially careful and tactful. . . . Responsibility for the patient's care rests with the physician in attendance. If he should retire from the case, the consultant must not replace him during the present illness, except at the request of the attending physician or with his approval."

Referred Hospital Patients

The paragraph, "Patients Referred to Physicians or Sent to Hospitals", is entirely new. It sets forth the obligation of the physician and of the hospital to acquaint the physician referring the patient with the results of the examination made:

> "When a patient has been sent either for office examination or admission to a hospital under the consultant's care, it is the duty of the consultant to report findings and discuss them with the attending physician so that the latter may have all possible advantage from the consultation. It is equally the duty of the physician referring a patient to give as full information as possible to the consultant. A hospital physician should see that findings or suggestions of value concerning any patient at the time under his care in hosptial are sent to the physician usually in attendance on that patient."

While this means extra work for consultants, hospital physicians and hospital superintendents, it also makes for the benefit of the patient and promotes goodwill for the hospital.

Induction of Abortion

Another new paragraph is headed "The Induction of Abortion". Stress is laid on the fact that abortion is a violation both of the moral law and of the Criminal Code of Canada except when there is justification for its performance:

> "The only justification is that the continuance of pregnancy would imperil the life of the mother. Such an operation should never be undertaken unless the attending physician and consultant agree as to the necessity for such action; the consultant must be a physician in good standing and his recommendation should be put in writing. Where hospital facilities are available the operation should be performed in a hospital, and, in such case, the superintendent or head of the institution should be notified in advance."

Interference

Three acts of unprofessional conduct, interference, paid advocacy, and fee-splitting, are dealt with under the headings: A Physician as Visitor, Paid Advocacy and Secret Commissions.

> "When a physician, as a personal friend, meets the patient of another physician, or calls upon him when ill, he must be careful not to be drawn into interference through suggestions or opinions. These should never be expressed except when he has been called in consultation in the authorized way."

Paid Advocacy

The honourable physician will not become a paid booster of any commodity, however good it may be, neither will he sell his patient nor become a partner in any dishonest practice.

Fee Splitting

A secret arrangement between two physicians whereby unknown to the patient, one physician receives part of the fee paid to the other, is not consistent with the honour of the profession. Such a practice is dishonest and leads to trafficking in patients. The physician to whom a patient is referred may request the services of the referring physician as anaesthetist or assistant, and if the patient assents to the request, a fee may be charged by the referring physician for the services rendered. Occasions may arise when the complexity or obscurity of an illness demands the services of physicians practising in different fields of medicine; in such

case a composite fee may be arranged and distributed. Provided the patient is aware of this arrangement, the division of the composite fee does not conflict with the ethics of the profession.

The receiving of commissions connected with the sale of a commodity or with the referring of patients is entirely unethical conduct.

"It is undesirable that medical practitioners should have a proprietary interest in preparations or appliances which it may be their duty to recommend to patients." (British Medical Association's Decisions.)

Advertising

Since it is contrary to the dignity of the profession for a physician to advertise himself, the Code recommends, under the heading, Communications to the Laity on Medical Subjects, that "all opinions on medical subjects which are communicated to the laity by any medium, whether it be a public meeting, the lay press, or radio, should be presented as from some organized and recognized medical society or association, and not from an individual physician. Such opinions should represent what is the generally accepted opinion of the medical profession."

The basic rule underlying advertising is that the physician who takes part in any public medium of discussion should avoid methods which tend to his personal professional advantage. These are the methods of the charlatan and not of the honourable physician.

Discoveries

Advances or discoveries in any branch of medical science are not to be kept secret nor to be capitalized by the physician for his personal gain.

"Such advance or discovery should be made common for the advantage of the whole profession, and for the progress of science. There are well recognized methods by which physicians can place their work and discoveries before those who are fitted by education and experience to judge them. The lay press is not the proper medium for the first announcement of a physician's work or discoveries."

General

When, in the event of an accident or other emergency, a general alarm is sent out for physicians, disputes may easily arise. This contingency is guarded against in the Code:

"When a physician is called in the absence of the attending physician, or in emergency, he will, on arrival of the attending physician, hand over all care and responsibility, and retire from the case.

"In a case of sudden illness or accident when several physicians are called, the first to arrive should be considered to be in charge. However, he should withdraw in favour of the regular family attendant should he arrive, or of any other physician preferred by the patient."

Since physicians are human, sometimes very much so, differences occasionally arise. The method of composing such differences is laid down in the Code:

"Differences between physicians which cannot be adjusted after fair discussion should be referred to the Committee on Ethics of the local medical society. Complaints of unprofessional conduct should be referred in writing to the same committee and must be signed."

The Code enjoins that the medical witness should be actuated by a desire to assist the court in arriving at a just decision and not merely to further the interests of the party on whose behalf he has been summoned.

It has this to say of patent preparations: "A physician should not make use of, or recommend, any remedy, the principal ingredients of which are not disclosed to the profession."

A physician is not free to assume care of a patient who has had another attendant in the current illness, unless he has satisfied himself that those responsible have notified the other physician that his services are no longer required.

Relationship to Hospitals and Nurses

Other entirely new paragraphs in the Code are those relating to the Relations of Physicians In and With Hospitals, and Nurses and Nursing. Mutual understanding and co-operation must prevail. Hospital appointments should be regarded by physicians as positions of trust. The services of hospital physicians should not be exploited. Since these paragraphs are of special significance to readers of The Canadian Hospital, they are quoted in full:

"The modern hospital is a new element in the care of the sick and may not yet have become rightly adjusted in all its relations. Mutual understanding and co-operation between the profession and the hospitals are most essential.

Inasmuch as the positions held by members of the honorary attending staff give them unique opportunities for enlarging knowledge, such positions should be held as a trust for the advancement and teaching of medical science and for the general good of the community.

A physician may rightly apply for such an appointment but should not canvass for it. An appointment should never be given on account of party or favoritism but solely on account of professional standing, industry, the spirit of co-operation and the ability and willingness to teach.

Hospital appointments are positions of trust for the community and the advancement of science.

The Board of Management of a hospital has no right to dispose of the free services of physicians except as approved by the organized profession. It is the duty of hospital boards or executives to see that the free services of physicians are not asked for, or given to, or exploited for those who can and should pay, or for whom payment should be made.

While 'God's Poor' should always be cared for with charity, it should be understood that the physician gives his services as an act of courtesy but not of obligation."

"The profession of nursing has grown up to share in the care and prevention of illness, and the betterment of general health. In this large undertaking the services of the two profession, being complementary to one an-

(Continued on page 81)

Taking Hospitalization Instead of Dividends

Unique Combination of Hospitalization with the Co-operative Movement Proves Successful

By REV. SISTER JOHN BAPTIST,
St. Martha's Hospital, Antigonish, N.S.

THE brief story of an experiment in co-operative hospitalization, one of the salient features of what is generally known as the "Antigonish Movement" may be of interest to the readers of The Canadian Hospital.

In order to place the project in its proper setting, it is necessary to outline the philosophy and the principles underlying the movement.

This co-operative movement is sponsored by the University of St. Francis Xavier, a small institution of learning in a small centre, handicapped by poverty, but always noted for its high educational standards and the quality of its work. In fact it is and always has been recognized as a veritable hot bed where ideas of progress and expansion are generated. Situated in a country town in eastern Nova Scotia, surrounded by a sparsely settled rural area, this University would seem to lack the advantages of similar institutions throughout Canada. The chief industries of Antigonish and Guysboro counties are farming and fishing; a little further afield in Pictou county and on the Island of Cape Breton stand the soot-blackened towns where hard working men eke a living from the bowels of the earth in the coal mining areas. In such a setting one might naturally ask—"Can anything good come from Antigonish?"

Farmers, fishermen, miners and other labourers were groaning under the yoke of the prevailing economic system. Long before the depression of 1929 clouded the world, many of the finest types of our young men and women were drifting towards the United States and Western Canada. Those also who received the advantages of higher education were drifting with the tide to more prosperous centres. Agriculture waned, farm lands deteriorated, vacant homes and smokeless chimneys became the land marks of a once prosperous countryside.

The thinkers and intellectual men of the University saw that immediate action was necessary, but first of all they must plan a program and lay a secure foundation. The people must be awakened to a new sense of reliance in themselves and be taught to help themselves. Education was, of course, not only necessary but of paramount importance—an education that would meet the immediate needs of the people and prepare them for action. Gradually the leaders of the movement began to unfold a philosophy and a technique that is destined to re-make the social and economic life of the country.

Study Clubs

The people were shown how to better their lives spirtually, culturally and intellectually when their stand-

St. Martha's Hospital, Antigonish, N.S. Nurses' Residence, St. Martha's Hospital and St. Martha's Sanatorium.

ards of living were raised. Study Clubs were organized, the right kind of reading and plenty of it was placed on the plain shelves of the Extension Department to which the people had free access. In all this reading and study the people were encouraged to do their own thinking and form their own conclusions. In the farmhouse kitchen, with the kettle singing over a bright wood fire, ready for "the tea", and admidst the fragrance of tobacco smoke (which greatly helped to stimulate ideas) vital questions were discussed and plans were formulated in study clubs of not more than twelve or fourteen. The same activities were in evidence in the homes of the miners and the fishermen. The different groups would occasionally meet together in some centre and then live topics were discussed at debating contests. Able men in the University Extension Department were always willing and ready to give the necessary assistance.

One of the buildings of St. Francis Xavier University, Antigonish. The remarkable work of the extension department in the field of co-operative endeavour has given this University a world-wide reputation.

The Co-operative Movement

It was in this way that old and young were led to tackle their own problems. They studied capitalism and found it collapsing under the weight of its own sins. They studied the opportunities which Communism and Fascism offered as a remedy for our social and economic ills and rejected them. Finally their search led them into the field of co-operation, and herein they discovered something akin to a new star of hope rising over the distant horizon. They studied the Rochdale principles of co-operation; they studied the movement in the United States and the Scandinavian countries. However, their leaders recognized that something more than a bare system of co-operative buying and selling was necessary in this case. They saw the necessity of a set-up which would represent a real, vital philosophy, as well as social and economic security. Thus were the people awakened to a sense of spiritual, cultural and social responsibility. As one of the leaders aptly remarked —"We must put the common man in the driver's seat with his hand on the throttle of his own destiny".

Many of the original objectives outlined by the St. Francis Xavier Extension Department in formulating their plan of action have been attained in whole or in part, while many new objectives have been adopted. Study clubs increase in number and continue to explore new fields of knowledge and activity. Co-operative Societies wax stronger year after year as their numbers are augmented and their memberships increase. Though the "Antigonish Movement" has barely touched the surface of the possibilities before it, each year has brought a gratifying report of progress, as the list at the foot of next column shows.

During the present year a co-operative housing association was organized and one community of eleven units is now under course of construction.

The result of the Antigonish Movement, however, is not measured solely by economic gains, but much more significant is the change in the spirit and mentality of the people, and their general outlook on life. While the University of St. Francis Xavier is a Roman Catholic institution of learning, no denominational lines are marked in the program outlined here. The president of the Industrial and Rural Conference, from which this movement arose, is a clergyman of the Roman Catholic Church, the vice-president is a minister of the United Church of Canada, and the secretary is a layman. Religious, racial and political differences are forgotten in the laudable desire of making this a better world in which to live. A fine spirit of comradeship and helpfulness marks the activities of this widely diversified group.

St. Martha's Hospital, Antigonish, with its School of Nursing affiliated with the University, could scarcely help catching the spirit of the movement. While its rates are the lowest in Eastern Canada, the authorities of the hospital saw the difficulty experienced by the average family in meeting the cost of sickness. As this institution served for the most part a large and scattered rural area, it was rather difficult to form the usual plan of group hospitalization. Consequently, it was felt if adequate hospital service was made available at the least possible cost, without crippling the hospital financially, it must come from some other form of community or group action.

Co-operative Hospitalization

The St. Andrew's Co-operative Society, operating through a small store in St. Andrew's about eight miles from Antigonish, was considered the strategic point from which to start a plan of *co-operative hospitalization*. This society was doing good business and stood on a sound financial basis, as may be seen by the fact that during the past five years, the two hundred and twenty shareholders have been paid $16,500 in percentage dividends! So the men of St. Andrew's (being for the most part of Scottish

	1932	1933	1934	1935	1936	1937	1938
Study Clubs	179	350	650	940	860	1013	1013
Membership	1500	5250	6000	10650	8000	10000	10900
Credit Unions	8	19	27	45	65	90	142
Membership							18000
"Co-op" Stores	2	4	6	8	18	25	33
" Buying Clubs			3	10	5	4	3
" Fish Plants		3	5	5	10	11	11
" Lobster Plants		8	12	14	17	17	17
Other Co-operatives			2	2	2	7	8
Leadership Short Courses: Attendance		86	44	30	63	76	132
Extension Dept. Staff: Full time	3	4	5	5	5	7	11
Part time	2	2	2	3	4	9	4

(Continued on page 82)

The Laboratory as a Clinical Aid

By M. C. DINBERG, B.Sc., M.D.,

Fellow in Pathology, Richardson Pathological Laboratory, Kingston General Hospital, Kingston, Ont.

IT is a notable fact that the clinical laboratory has emerged from the obscurity of the hospital basement, both figuratively and literally. Forty years ago, if a hospital possessed a laboratory, it was usually placed in an out of the way corner; its chief function was routine urine analysis. As a clinical aid the laboratory was a more or less functionless adjunct, often a barely tolerated nuisance.

But the development of scientific medical knowledge and the evolution of the art of medicine into a science, based upon discoveries in pathology, serology, bacteriology, parasitology, biochemistry, and the other fundamental medical sciences, has lain in those laboratories which had such feeble beginnings at the turn of the century.

Nowhere can one mark more clearly the forward march of medicine than in a study of the development of the modern clinical laboratory. To-day physicians turn to the laboratory for aid in diagnosis, and guidance in treatment and prognosis, provided by routine and special tests. On this basis one can safely say that the clinical laboratory has become the diagnostic laboratory, fulfilling its ultimate aim.

The laboratory exists by virtue of two purposes: diagnostic service to clinicians and scientific research. Of the latter, little need be said. The importance of scientific investigation cannot be measured in words but in the hospital laboratory, at least, it should never supersede the primary purpose of diagnosis.

From the fundamental sciences has arisen a highly specialized branch of medicine, clinical pathology and bacteriology, whose scope covers chemical, serological, bacteriological, and pathological tissue examinations. On these tests, the laboratory supplies data. The clinician interprets and correlates this data with bedside observations, on occasion aided by the pathological staff.

The diagnostic aid which a laboratory can offer is limited only by the experience of the personnel and the available equipment. Among the more generally available tests are routine haematological examinations, routine urinalysis, erythrocyte sedimentation tests, cerebro-spinal fluid cell counts, and the more simple bacteriological examinations. With a staff of two or more well trained technicians, and adequate equipment, many more valuable examinations may be added to the routine, such as various bacteriological agglutination tests, serological tests for syphilis, blood chemistry tests, etc.

Nowhere is the diagnostic value of the laboratory more clearly or more dramatically exemplified than in the "typing" of pneumococcus-pneumonia sputum. With the present variety of therapeutic sera found effective in combatting the various types of pneumococcus pneumonia, it becomes necessary for the clinician to know as soon as possible what the pneumococcus type is, in order to insure prompt specific therapy. The busy practitioner, who usually cannot afford a private technician, has, in the modern laboratory, a depot where sputum can be typed and the report delivered with a minimum delay, often within the hour.

To some clinicians the laboratory acts merely as a clearing house for their patients' excreta. But to most medical men, routine laboratory service has become a recognized and welcome aid in solving diagnostic problems. The clinical laboratory cannot make a good physician out of a poor one, but it can aid a good physician to become a better one.

Catholic Hospital Directory Gives Canadian Statistics

The special directory number of Hospital Progress, the official journal of the Catholic Hospital Association of the United States and Canada, contains statistics for 1937 on Catholic Hospitals of Canada and Newfoundland that are of interest to Canadian hospitals.

Four new hospitals were built during 1937, making a total of 169, while bed accommodation was increased by almost three hundred bringing the number to 28,494. Patients per day numbered 22,272 with a total of 482,384 admitted during the year 1937. Percentage of occupancy increased approximately 15 per cent over that of 1936; patient days numbered 8,269,280, a 5 per cent increase over the 1936 total of 7,873,314. The average stay in hospital was 17.1 days for all types of hospitals.

Four hospitals have been added to the list of those fully approved by the American College of Surgeons—three of which were formerly conditionally approved hospitals; at the present time 45.6 per cent of all the Catholic hospitals have the approval of the College. Three additional institutions were added to the number of hospitals approved for internships.

Under Allied Agencies for Canada, of the total number of 98 listed, 76 are grouped under the head of hospitals and other medical agencies; 19 as institutional services, and 3 as visiting nurse services. These 76 agencies of Canada provide 6,844 beds, not included in the previous totals. They include 21 general hospitals too small to be included in the list of hospitals; 15 institutions devoted to the care of chronic patients; 10 hospitals for incurables; 7 convalescent institutions; 3 maternity hospitals; 4 tuberculosis sanitaria and 16 which are devoted to various specific purposes. Of the 19 institutional services in Canada, that is, infirmaries and similar divisions for the care of the sick in convents and special schools, 14 contain 3,099 beds.

Pathology

Bacteriology *Biochemistry*

—Illustrations Courtesy of Kingston General Hospital.

Health Service to Employees at Salem Hospital

By J. ROBERT SHAUGHNESSY, M.D.,
Health Officer, Salem Hospital, Salem, Massachusetts, and
OLIVER G. PRATT,
Superintendent and Chairman, Small Hospital Section, American Hospital Association

HOSPITALS are primarily health agencies and, as such, should set an example as far as health measures are concerned. In this connection the hospital bears a definite responsibility towards its employees—a responsibility which, when accepted, yields a three-fold dividend in benefits to the employee, the patient and the hospital itself. When a definite plan to safeguard the health of employees is recognized as a part of hospital routine the employee is protected from infection carriers among his fellow workers and his general health is cared for; the danger of infection of patients through food handlers is overcome; and the standard of health and well-being throughout the whole hospital is raised.

Does your health program cover all employees, or only certain groups?

Considering these advantages, the lack of health service plans in many hospitals is quite surprising. Many hospitals have excellent health service plans in operation while there are others where very little is being done along these lines. The Salem Hospital has been operating a health service plan for four years and feels that this service is not only desirable but necessary to the well-being of the institution.

The Salem Hospital Plan

The pupils in the nursing school, of course, have always had their health well supervised, and are subject to an annual physical examination, X-ray examination of the chest and various immunizations. But the "service" group have been overlooked in many institutions. This group includes all maids, waitresses, ward helpers, male nurses, orderlies, mechanics, service men, laundry workers, laborers, in short, *everybody* connected with the hospital except the nursing school and the clerks in the office.

All newly employed individuals are employed subject to the passing of a satisfactory physical examination. In case of accident or sickness the department head sends the sick or injured employee to the Out-Patient Department, where he or she is seen by the health officer. He examines the patient and directs the treatment. When the employee is sent or seeks treatment, a blank is made out by the head of the department "Requesting Treatment", and on the same form there is a duplicate disposition blank which the health officer fills out—one part going back to the head of the department and the other going to the superintendent's office. This tells the department head whether or not the employee is able to continue at regular work; whether or not light work is advisable; whether or not the employee should be hospitalized, or perhaps be sent to bed in her room, or sent home. The superintendent is made aware of any accidents or any danger of infectious or contagious disease in the institution. All personal advice and treatment is carried out without communication to the department head or the superintendent, except to advise them as to the patient's ability to perform his or her duties. Our records are separate and independent of hospital records and are not open for the inspection of curious employees.

Every employee has the right to consult and be treated by a private physician or family doctor, but, before returning to work must satisfy the health doctor that he or she is fit and capable to return to work.

The physical examination given is complete and also includes complete blood, urine, Wasserman, and Widal test for any and all food handlers. Our employees are given routine and regular inoculations against typhoid and vaccinations against smallpox.

Employees handling food who are suffering from slight upper respiratory infections are obliged to wear masks covering nose and mouth. Any employee requiring hospital care, either medical or surgical, is admitted to the ward as a part of this hospital service. By having this organized co-ordinated health service any institutional epidemic outbreak is quickly and completely investigated and employees thoroughly examined, thus affording prompt and effective control of any such unfortunate happening.

Illustrative Cases

In our brief experience with the service there have occurred many instances which seem to prove the extreme importance of this extra care and protection of the employees. A few illustrations might well demonstrate some points of value:

Several years ago before the health plan was instituted a ward maid in the hospital, a young girl about twenty-one years of age, had a slight but rather persistent cough and was advised to see her local physician; this she claimed to have done and began taking a cough medicine. Her cough became somewhat worse and a few months later she left the hospital to be married. Four months later she was seen in the clinic, and examination revealed a moderately advanced tuberculosis. Her previous physician was interviewed and he stated that he had neither seen nor prescribed for the patient. She was later questioned about the matter and admitted refilling another girl's prescription without having seen a physician in regard to her cough. This illustrates the importance of a well co-ordin-

(Continued on page 83)

Three Forms of Personnel Insurance at the Winnipeg General Hospital

Pension, Group Life and Group Sickness Insurance All Available

By FRANK APPLEBY,
Chief Accountant, The Winnipeg General Hospital

1. The Pension Plan

In July, 1932, the Winnipeg General Hospital started a plan, originally requested by the employees themselves, to provide old age pensions for those employees who had reached the age of 65 years.

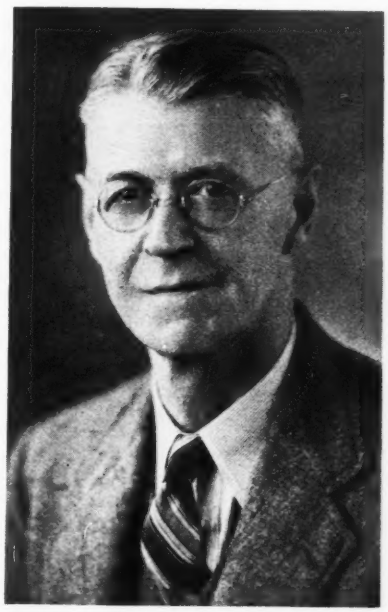
General:

After investigating several schemes then in force, including the City of Winnipeg Employees' Plan, and also some of the Insurance Companies' policies, that of a well-known Insurance Company was chosen (namely, the Sun Life of Canada).

The policy provides the following:

A pension of half the employee's salary at the retiring age of 65 years (female employees at 60 years) on a co-operative basis, the employee contributing an amount to bring in half the required pension, and the Hospital paying for the other half.

Separate policies are issued to each employee, stating the amount to which he is entitled on reaching retiring age, and in addition to this guaranteed amount, which is *less* than half the pension needed, dividends are to be added as earned, which it is expected will bring the pension up to the required amount. The Hospital also receives a Master Policy covering all participants at present insured, as well as all future enrolments.



Frank Appleby.

Premiums are collected by pay roll deductions monthly.

The premiums paid by employees vary according to age, from 4% of the salary earned on ages up to 34 years, increasing to 13½% at 55 or 56 years of age. It was thought that any premium of more than 7% would be too burdensome on both parties, so that 7% was agreed on as the maximum. The employee, in cases where the premium was over 7%, would only contribute that amount, and would receive a corresponding smaller pension. Thus, a person who would require 10½% premium to produce a half salary, would pay only 7% and receive only 2/3 of the usual pension.

It is requisite for participation in this plan that employee be 21 years of age (female employee 25 years), and has worked one year continuously for the hospital.

Employees with over 25 years' service are dealt with separately.

Benefits:

No pensions are payable until after 10 years' participation in the plan. Should an employee leave the employment of the hospital before the retiring age, he may:

(1) Keep up his share of the pension by paying the premium direct. (The Hospital pays no further premiums and is refunded 95% of all it has already paid);

(2) Receive a proportion of the money paid in after three years' participation (no premiums are returnable until after three years), varying in amount up to 95% after 8 years.

On reaching retiring age, the pensioner has a choice of the following:

(1) Receive the full amount of pension until death.

(2) Receive a smaller amount until death and his dependent receive a like amount until his or her death.

(3) Receive a smaller amount and his surviving dependent receive half the amount until his or her death.

(4) Have the pension paid for a certain number of years whether the pensioner lives or not.

Provision is made for total disability before the retiring age on payment of a small increase of premium.

Employees may be retired at an earlier age than 65 years at the request of the hospital and will receive a proportionate pension.

Employees may be continued in employment after the retiring age, if approved by both parties, and on continued payment of premiums, receive a proportionately larger pension.

The premiums paid by the Hospital are not entitled to any dividends and are consequently smaller than those paid by the employee. When an employee leaves the service of the Hospital before retiring age, 95% of the premiums paid by the hospital are returnable, but in case of death before retiring age, no premiums are returned.

This plan is not compulsory—the employee having the right to refuse participation.

Having been in force about six years, no pensions have yet been paid, nor will be for a few years to come.

Owing to the fact that this plan was put into effect soon after a considerable reduction in salaries all round had been announced, and a feeling that another reduction loomed in the offing, the response to the plan had dropped considerably by the time the policy was drawn up, and as financial conditions grew worse, further additions to the number who originally signed up were refused. The plan has been confined, therefore, up to the present, to those few who formed the original membership.

It is hoped, however, that in the near future, this plan will be re-opened for participation by more employees, several of whom have signified their willingness to join the plan.

The writer personally is strongly in favour of the scheme, as it not only gives the employee a sense of security, which is badly needed these days, but has also a tendency to make employees more loyal to the Hospital and to feel that something is being done for them besides merely paying wages.

Another advantage is that even if an employee does not remain employed by the Hospital until retiring age, he has a substantial amount saved up when he leaves.

The hospital also is relieved of any sense of moral responsibility to an old and trusted employee who may otherwise have to be kept at work, which he is no longer capable of performing.

2. Group Life Insurance

This is the usual Group Insurance, under which all permanent male employees are insured for $1,000 each. This is compulsory with all new members of the staff over 21 years of age, with the exception of professional men, and comes in force after three months' service. Several members of the staff who were employed by the hospital at the inception of the plan did not take out this insurance, and are still working here uninsured. Eighty-eight employees are insured under this plan. Some of the female staff are included in this number, but it is not compulsory with them.

Premiums vary in amount according to age, ranging from $6.08 per annum at 21 years of age, to $115.32 at 77 years, which is the age of our oldest employee. The average rate is about $16.00 per year, and of this amount the employee pays $7.20 and the hospital $8.80, or 45% and 55% respectively. The hospital contribution amounts to about $700 per annum.

All premiums are adjusted according to age annually, and the average rate is then struck and remains in force until the next adjustment—withdrawals by leaving the hospital or death and new members coming into the plan are deducted or added at this rate. The dropping out of the more aged employees means a very considerable reduction of premium (the withdrawal of the one of 77 years of age would mean a saving of over $100 a year to the hospital).

Several claims have been paid under this policy, and in nearly every case the money has been a veritable godsend to the widow. It also does away with taking up subscriptions or "passing the hat" and is much more satisfactory from a financial standpoint.

3. Group Sickness Insurance

This is purely an employees' plan, and is confined to the Power House and Administrative employees (male only). The hospital has nothing to do with the plan, except to collect the premiums through pay roll deductions monthly, and transmit the amount so collected to the Insurance Company.

This policy covers all sickness and accident, except those covered by the Workmen's Compensation Board, and also covers total disability from any cause.

The Group Plan, by its ease of collection, reduces the premium considerably.

It has proved to be a very satisfactory plan.

Vancouver General Employees Given Award

The arbitration board, set up by the provincial government under the B.C. Industrial Disputes Conciliation and Arbitration Act on the Vancouver General Hospital salary dispute, ruled that male employees of Vancouver General Hospital were entitled to better wages and working conditions. The concessions which came into force October the 1st, are as follows:

1. That the requests of the lay male employees of the Vancouver General Hospital are, in the main, fair and just and that the scale of wages now in effect is subject to revision upward, and that they are entitled to adjustment of working conditions, as hereinafter set out.

2. That there shall be paid by the Vancouver General Hospital to all the male lay employees in the lowest brackets, a salary based on a minimum rate of not less than 40 cents an hour.

3. That all shifts be of eight hours per day and, where the shifts are broken as to time, the spread is not to exceed twelve hours in point of time.

4. No employee to work more than six days per week on a straight time basis.

5. All overtime to be paid at the rate of time and one-half.

6. That all be given two weeks holidays each year, with pay.

7. That all be paid wages at rates set out in a schedule.

The schedule of wages awarded grants increases in some categories ranging from $5 to $10 a month over those paid in June of this year.

Saskatchewan to Have Director of Hospital Administration

Dr. C. F. W. Hames, medical officer and acting deputy minister of public health, has been promoted to the additional position of director of hospital administration for Saskatchewan.

An English Pension Plan for Nurses and Hospital Executives

A PENSION plan, which, since its organization in 1928, has been adopted by hospitals representing nearly 80 per cent of the total voluntary bed-complement of Great Britain and also by a large number of other nursing and charitable institutions, is now operating successfully in Great Britain. It is called The Federated Superannuation Scheme for Nurses and Hospital Officers (Contributory), is incorporated, and has its registered office at 21 Cavendish Square, London, W.1. Some 1,065 institutions are members.

The scheme is a contributory one providing benefits commensurate with the career of each individual member. Its provisions cover every possible circumstance which may arise during each member's career. The scheme is under the administration management and control of the Central Council operating through an elected executive.

Eligibility for Membership

Subject to certain options and exceptions, membership in the scheme is compulsory. After the adoption of the scheme, membership must be one of the terms of engagement of all Trained Nurses (i.e., those who are State Registered or who hold a certificate for general, sick children's, fever, mental or mental defectives' training); all Male and Female Officers (administrative, clerical, dispensing, massage, etc.), in receipt of remuneration (salary and emoluments) of £160 p.a. or more.

Membership is optional for:

(a) Employees in the service of the institution on the date it adopts the scheme;

(b) Probationers during training (i.e., the hospital on adopting the scheme has the option of deciding whether it will include probationers in the scheme or not. If included, they are not eligible during first year of training);

(c) Assistant nurses (i.e., those not holding a certificate for general, sick children's, fever, mental or mental defectives' training) employed by a participating institution;

(d) Administrative staff members in receipt of remuneration (salary and emoluments) of £100 p.a. but less than £160 p.a.

Applications for membership can be accepted as under: Officers, Matrons, Assistant Matrons and Male Nurses up to the age of 59 next birthday; other nursing staff up to the age of 54 next birthday.

Contributions and Benefits

Contributions (payable as to two-thirds by the employing participating institution and as to one-third by the member), are applied as premiums on insurance policies effected in the name of the Central Council of the scheme. Increment policies, securing additional benefits, are effected at successive stages in the individual's career. Provision may also be made for "back service" (i.e., service prior to the adoption of the scheme by the institution).

Fifteen per cent of total remuneration (salary and emoluments), payable as to two-thirds (i.e., 10%) by the institution and one-third (i.e., 5%) by the member. The rate of contributions depends only on the rank and/or salary, and is not affected by the age of the member.

The ultimate benefits secured depend on the age at entry, the period of contributory service, the rank and salary attained, and the class of policy and insurance office selected.

If the member wishes to do so, he or she may select the insurance office with which the policy is effected. The quotations furnished by twenty-four insurance offices have been approved and accepted by the Central Council for the purpose of the scheme. Uniformity of policy conditions has been secured and each insurance office has quoted net rates. Since no commission is payable to anyone, the whole of the contributions are used to obtain the maximum benefit for each member.

Other Provisions

Provisions are made for: specific age retirement, if desired; continuance of member's services after maturity date; choice of taking on retirement a single cash payment or a pension, or partly cash payment and partly pension; termination within a period of from 5 to 10 years of membership, according to the class of member, whereby contributions, with compound interest, are returned to the participating institution and the member (assuming a Deferred Annuity Policy is effected); the payment to the legal personal representative of a deceased member of the proceeds of all policies effected.

Policies are written to mature from the 55th to the 60th year. No benefits are payable until the nurse has definitely abandoned the nursing service (or in the case of officers, hospital service) as defined in the scheme, whether before, on, or after the maturity of the policy.

Successful Hospital Fair at Digby, N.S.

Proceeds of Digby's annual Hospital Fair were approximately $1,600. This year's total was the highest in several years.

* * *

Jewish Hospital for Incurables Planned

Architect's plans have been prepared and a site granted by the city of Montreal for the proposed Jewish Hospital for Incurables. A campaign for $100,000 for construction began in September. C. B. Goodman is architect.

Records and Reports on the Hospital Ward

By MARY E. MACFARLAND, R.N.
Ward Supervisor, Toronto General Hospital

CONSIDERABLE progress has been made in the matter of records and reports within recent years. The value and importance of correct and up-to-date records have been emphasized and interest demonstrated in the problem. There is a limited amount of material available in the literature on the subject. However, an intelligent approach, thought and discussion should provide help and inspiration and result in improving or modernizing the present systems.

Principles

Fundamental principles lie at the basis of institutions and technics. These should be thoroughly understood and frequently analysed.

Accuracy: Details should be exact, precise and give a true picture.

Legibility: Records must be easy to read; carefully spaced, preferably printed, and words used, unless symbols are from an approved list.

Brevity: Concise, short phrases are efficient.

Validity: Sound statements carry meaning and are conclusive. Ambiguities should be avoided.

Uniformity: Regularity may lead to conservation of time and energy.

> *The nurse who can visualize the ultimate purposes for which records are kept and to which they may be applied will appreciate that recording is an important feature of her work and education.*

Classification

Certain records have a place of recognition in the administrative and professional aspect of ward management. These will be dealt with briefly and may be classified:

Administrative Records: In this division are included the service and supply requisitions, made out daily, weekly or monthly. It is advantageous to have a set time for ordering various supplies and these are charged to the department. Requisitions should be carefully made out. Signed or duplicate slips are sent to the accounting office. Departmental costs are computed from these.

Educational Records: These comprise the efficiency and experience reports and serve as a means of evaluating the personality, professional fitness and practical experience of the student.

Informational Records: Under this heading fall the admission slip, clothes check and discharge slip. In some hospitals, these are covered by the statistics card. Minimum information regarding the patient is necessary; further social data desirable.

In this class are contained also the seriously ill, day and night reports of patients, bed census and the notification of deaths and transfers.

The Clinical or Medical Chart: The importance of a good Clinical Record must be recognized. This document deserves particular consideration. Warren P. Morrill says: "Nothing tends to clarify ideas better or to lead to more accurate thinking than the effort to express those ideas in the written word". Let us attempt to estimate the worth of this record.

Utility and Value of the Clinical Chart

To the Patient: Information that is accurate and available serves the patient, is a guide during the treatment of his present illness and the permanent record may be used in his interest in case of future illness. Time and expense are avoided when information is readily obtainable.

To the Hospital: The quailty and quantity of work in the hospital may be analysed and results evaluated.

To the Physician: Doctors examine the character of their own work and in teaching, hospital lecturers use the clinical record in the formal education of the medical student.

In Medical Research: Material is available if facts have been recorded.

In Legal Defence: The record written at the time the alleged error occurred may strengthen the evidence and exonerate physician, nurse and hospital.

Form and Contents of the Clinical Chart

Many hospitals have their own collection of forms.* Outlines are sometimes provided and the data is written, printed or typed in. Record keeping is conceded to be essential and recording constitutes an integral part of a nurse's training on the ward.

The Graphic Chart Sheets are placed on top of the record in the reverse of the chronological order. These give a well delineated picture of the patient's temperature, pulse and respiration. There are often spaces on this form in which additional information may be entered.

There are several systems for securing written orders. The blank order book is commonly employed. Malcolm T. MacEachern recommends the use of a *Physician's Order Sheet or Prescription Record* which is made out in duplicate, the carbon copy serving as a permanent record. Transcribing orders from the book or form to *The Treatment Sheet* remains inevitable. A glance at this sheet may suffice to approve the treatment or effect a change.

*Approved forms may be obtained from the Hospital and Medical Records Co., 177 Jarvis St., Toronto.

The Nurses' Clinical Record

The clinical record is the nurses report of facts concerning the patient. The nurse who makes the observation or administers the treatment should record the same in writing at the time the service has been rendered. Insignificant information should be omitted, but any significant fact is worth noting. The physician relies on the record and having duly considered it, may accordingly suggest treatment. Hence, its importance, and all the principles of recording should be put into practice when constructing it. Failure on the part of the nurse to provide exact, definite information may delay recovery or even endanger the life of the patient. Judgment, discrimination and skill should be displayed in recording, and nurses' notes may often establish a valuable contribution to the history of the patient and serve as convincing evidence in Medico-legal cases. With these reasons in mind, it is suggested that the Clinical Record should bear the signature of the nurse who has constructed it.

The clinical or medical chart includes a history of facts and subjective symptoms of the patient's illness. The physician records his observations and findings of the physical examination. The laboratory sheet, reports of adjunct diagnostic services, non-operative or operative treatment, permission for operation, anaesthetic record, report of operation, pathological report, progress notes and final summary note comprise the complete record. In case of death, if autopsy is secured, the authority is added to the chart, as is the subsequent report of the post mortem examination. When the patient has refused treatment of the physician or hospital, a removal slip is signed and attached to the chart. A thorough history should be written on every patient. The record is a comprehensive picture of the patient's condition and contains the data needed to make the diagnosis and justify the treatment.

Procedure to Produce Better Records

Re-organize the teaching of charting, to stimulate interest and produce better records. Continue training progressively in the actual situation after the basic instruction has been given. Use records as teaching material. Clinical recording may well be recognized as an extension of bedside nursing.

Is the nurse far-seeing who does not visualize the purpose for which records are kept? If she realizes this, she will appreciate that recording is an important feature of her work and education. Does it seem quite unnecessary to intimate that *supervision* is vital? Guidance and inspection should be provided for then and only then, good record keeping on the ward in the hospital is assured.

*Presented at the School of Nursing Refresher Course on Records, Toronto, Ont., February, 1938.

Opium and Narcotic Drug Act Amendments, August 1938, and Hospital Routine

A hospital administrator has inquired if the amended Opium and Narcotic Drug Act, which was sent to hospitals a few weeks ago, requires a change in hospital routine. Regulation 10, effective August the 1st, 1938, would appear to require not only a record of the name and quantity of the drug issued and the date, but also the name and address of the physician, name and address of the person receiving such, etc. If literally interpreted, this would add considerably to the clerical work in each hospital.

We have been informed by Colonel C. H. L. Sharman, Chief of the Narcotic Division of the Department of Pensions and National Health, that "there is no desire whatever to add to the administrative burden of hospitals in relation to the control of narcotics. When amendments to the Act were recently under consideration it was deemed advisable to take power to ensure that narcotic records were being kept in hospitals. This, of course, we are fully aware is being done in large institutions, but there were some of the smaller types in relation to which there was considerable doubt".

All purchases should be recorded in such a way as to give the date, the drug, the amount, from whom purchased, and the cost. All narcotics given to patients should be recorded in a book which gives the patient's name, the date, the year, the drug, and the amount given, and the nurse's initials. All narcotics given should be recorded accurately, as to drug, amount and time on the patient's chart and should be properly recorded in the doctor's order book. "We have merely provided that records shall be kept in order that, as and when the necessity arises, as it does several times a year, there are records available which can be examined by the Officers of this Department." (See The Canadian Hospital, December, 1937, page 13.)

The Office Consolidation recently issued by the government illustrates Form M-11, which is a form for use by retail druggists to indicate the receipt of narcotic drugs, and Form M-12, which is a form for retail druggists for sales of narcotic drugs. To our inquiry if it would be desirable that hospitals should use such forms the reply was to the effect that such usage did not seem necessary as the essential information would be available for examination, if and when, circumstances would require.

Cobourg Hospital Board Mourns President

We regret to report the death of John D. Hayden, former president of the Cobourg General Hospital Board, Cobourg, Ont., who died on September the 11th.

Mr. Hayden, a man of many interests, was well known for his efforts in behalf of his community's welfare, but perhaps his greatest work, certainly the work nearest his heart, was the establishment of the Cobourg General Hospital. In 1912, when the hospital board was organized, Mr. Hayden was made president, and he held that position for twenty-six years until his death. He gave unstintingly of time and energy, and his work in raising funds and his insistence on the highest standards for the hospital have been the chief factors in bringing it to its present fine position.

Obiter Dicta

A Far Reaching National Health Program

WILL the Roosevelt government attempt to accomplish in one fell swoop all—and more—than has been accomplished in the way of health legislation in other countries in the past two generations? The more one studies the sweeping recommendations of The Technical Committee on Medical Care to the Interdepartmental Committee to Co-ordinate Health and Welfare Activities and presented at the National Health Conference held at Washington this summer, the more one realizes the tremendous significance of these proposals. Based on the governmental National Health Survey of 800,000 families including 2,800,000 people, presented last year, this solution to the health needs of the people would transfer the United States from almost the foot of the list to right up among the leaders in government participation in medical and hospital support and control.

The five recommendations are indeed sweeping. They are, in short: (1) an expansion of public health services to combat tuberculosis, venereal disease, malaria, cancer, mental and other diseases at an annual expenditure of $200,000,000, to provide maternal and child health services at a cost of $155,000,000 and services for crippled children at $10,000,000; (2), expansion of general and special hospital facilities at an annual cost of $146,050,000; (3), the provision of essential medical services, hospitalization and emergency dentistry to those on relief or unable to bear the extra expense at a cost when fully developed of $400,000,000 annually; (4), a general program of medical care largely under state jurisdiction and financed through general taxation and special assessments or by specific insurance contributions from those insured; (5), insurance against loss of wages during sickness. No attempt was made to estimate the cost of the as yet undeveloped fourth and fifth recommendations.

No conclusions were drawn at the National Health Conference. Rather was it an occasion for the exchange of views by the many groups invited to participate. Welfare and social workers in general were enthusiastic in their support; the A.F. & L. supported the measure but the C.I.O. gave the impression that it would do so only on a non-contributory basis. The American Medical Association pleaded careful consideration and action in the adoption of such a momentous program.

The *hospital program* is being carefully studied by the American Hospital Association. An analysis of existing hospital facilities points out that 1338, or over 40 per cent of the counties, with 17,000,000 people, have no registered hospitals; tax supported tuberculosis and mental hospitals are overcrowded; outpatient services are lamentably scarce and even in cities of 50,000, not more than one half have such facilities. It is proposed to add 180,000 general hospital beds to bring all state averages up to 4.5 per thousand of population. Most of these would be new units in areas now unprovided for. Some 500 hospitals of 50-60 beds capacity are recommended for rural areas. The present 65,000 sanatoria beds would be supplemented by an additional 50,000 beds. Some 130,000 additional mental beds are recommended also.

These are staggering figures. Perhaps a similar survey here would reveal parallel conditions. There is no question we lack mental and tuberculosis accommodation in most, though not all, provinces; our outpatient facilities are very weak except in the largest centres; we do know that a large percentage of our people have difficulty meeting medical and hospital bills. One doubts, however, if we have such a large proportion of the country without hospital facilities. Thanks to the stimulus of the provincial and municipal grants long since established and the post-war desire for a memorial, there is a remarkable network of small non-profit hospitals from coast to coast. Many of the features of this recommended program will meet with general favour; others will receive severe criticism. The American Medical Association held a special meeting of its House of Delegates, in Chicago, in September, and a number of constructive recommendations and suggestions were made. Of one thing we are certain, the hospitals and the medical profession to the south are destined during the next few years to face the most momentous period in their history.

Modernizing the Code of Ethics

EVEN so conservative and fundamental a document as a medical Code of Ethics must be revised from time to time to keep pace with changing conditions. The Code of Ethics of the Canadian Medical Association, the principles which constitute the basis of authority for professional ethics in this country, has been thoroughly

overhauled and, this summer, the new Code was officially adopted. In this issue Doctor Ross Mitchell of Winnipeg, who generously assumed the chairmanship of the Committee when the last call came to Doctor David A. Stewart of Ninette Sanatorium, reviews some of the articles, particularly those which relate to hospital practice and procedure.

Revision of this Code of Ethics did not mean changing ethical standards or modifying former views on various procedures. Actually the principles of ethical conduct, which were found to be the best over one hundred years ago, have proven their value over the intervening years and are still the cardinal foundation stones of the Code. But new problems have arisen or old issues have now appeared in new guises and the new Code endeavours to give guidance on these matters. The development of the hospital and the transference of a large proportion of medical practice to these institutions has set up a whole train of situations requiring sound ethical judgment. The advent of the radio and the broadcasting of health talks create other hazards for the ethical individual. The dictum that scientific discoveries must not be kept secret nor capitalized for personal gain is not palatable to those who would prefer to retain the profits for themselves. The increasing habit of some practitioners to prematurely herald their "discoveries" in the lay press before waiting for scientific corroboration and recognition in the scientific press is scotched in no uncertain terms. While the lay press is an excellent medium for the public dissemination of scientific truths, its ready acceptance in all too many instances of almost any announcement with "news" value, irrespective of scientific accuracy or proof, is grossly unfair to a hopeful and credulous public. On the other hand, the common attitude of the indigent, that the doctor *must* come when called and that his charitable service is an obligation, not a discretionary privilege, has been set aright in the new Code.

The whole principle of medical ethics has been badly misunderstood, largely, perhaps, because the physician has not taken the care to explain their *raison d'être*. The fundamental basis is protection of the public, not, as is commonly supposed, protection of the physician. An example is the ban on advertising. The objection to splashy advertising is not to deprive the public press of a few dollars, as many think, but because experience has proven that the public are best protected when a physician builds up his practice, not upon the claims of a publicity writer, but upon the recommendation of patients who have personal knowledge of his ability. It is the doctor who suffers by this delay in income and not the patient. Commissions and split-fees are of every day occurrence in business and these are quite "ethical", but where life is at stake the choice of a surgeon by a general practitioner should be based entirely upon ability for the task to be done, not upon which surgeon would give the largest rebate. Fortunately this practice is practically non-existent now among reputable doctors. Most public hospitals exact a pledge on this point from their staff members. Because of the intimate application of many articles in the Code to hospital work, this article by Doctor Mitchell will be of deep interest to our readers.

Congratulations

TWENTY-FIVE years ago, in September, 1913, *The Modern Hospital,* a brain-child of Dr. Otho F. Ball and Dr. John A. Hornsby, issued its first number, a stirring 144-page magazine, to what was then an almost virgin field for hospital publications. That first issue, with articles by Goldwater, Stevens, Ochsner and others of international repute and with such leaders on its Editorial Board as Winford Smith, Frederic Washburn, W. L. Babcock and Henry Hurd, gave bright promise of the remarkable development of this journal during the past quarter century. Through these years *The Modern Hospital* has given aggressive leadership or loyal support to every worthwhile development that has taken place in the hospital field.

Last month an unusually fine silver bound twenty-fifth anniversary number was issued. The general theme was a comparison of the methods, practices and equipment of 1913 with those of to-day. In his introductory page, the President, Doctor Otho F. Ball, recalls the statement in the first issue, "if through its efforts there shall come a higher order of service to the sick and suffering everywhere their ambitions will have been achieved". The full extent of *The Modern Hospital's* influence will never be known, yet there is no question but that this altruistic ambition has been realized many fold. To mark the occasion a delightful dinner was tendered to Dr. Ball at the Dallas meeting by his editorial board and other hospital leaders. *The Canadian Hospital* takes this opportunity to extend heartiest congratulations and every confident wish for the future to Doctor Ball, Doctor Joseph C. Doane, Mr. Alden B. Mills, Mr. Raymond P. Sloan and *The Modern Hospital* family.

Health of Radiological Technicians

OWING to the insidious hazards to which all workers in radiological departments are exposed, considerable thought has been given by radiologists to the protection of the personnel of these departments. This has been particularly necessary since the development of high voltage and more powerful equipment. Fortunately, the skin eruptions and loss of digits, which were so frequent among the early pioneers in radiology, many of whom finally suffered martydom, has been largely overcome by protective methods, but anaemias of an aplastic type are prone to arise, if the radiologists and technicians devote themselves too assiduously to their work. Ample recreation in the open air has been frequently recommended to prevent this possibility.

With a view to protecting the health of the radiological technician, the Canadian Association of Radiologists at its meeting in Halifax this summer passed a resolution which read: "All full-time X-ray technicians approved by this association or its local division shall be entitled to one month's holiday with pay each year, and that the Canadian Hospital Council be appraised of this motion."

This recommendation is in keeping with the last report of the International Committee on Safety in Radiology.

We understand that most of the larger hospitals and institutions employing full-time technicians are now living up to this principle, but there are still a number of hospitals where the radiological technicians have but two weeks' holiday in keeping with that provided to other employees. It is pointed out by the radiologists that this motion, of course, will apply only to technicians doing full-time X-ray work, and not to those devoting only part of their time to X-ray.

Canadian Honoured by American Hospital Association

AT the close of the Dallas convention, on September 30th, Doctor Harvey Agnew was inducted to the presidency of the American Hospital Association. During the last few years, Doctor Agnew has served as a Trustee of the American Hospital Association, giving evidence of eminent qualities as a leader and a wide knowledge of hospital affairs.

His election as President is looked upon by his Canadian friends in particular, and only God knows their number, as a well deserved honour and an assurance that the interests of the voluntary hospitals of both countries, in the face of decidedly new trends in State attitudes, will be served wtih the greatest vigilance.

It will be remembered that the American Hospital Association is scheduled to meet in Toronto, in 1939. The fact that the President is a distinguished Torontonian himself will undoubtedly make all of our hospital friends feel that they are doubly welcome, once again in Toronto.

One may easily surmise that the duties of a President of the American Hospital Association, before and during a convention, are not a sinecure. As Doctor Agnew possesses the very rare quality of being able to handle, at the same time, half a dozen full-time jobs, without ever seeming to be overburdened, we are sure that the meeting in Toronto will be the climax of a bright, wise and resourceful term of office. And these are the wishes we would like to express, with our congratulations, to the new President.

—Georges Verreault.

Higher Hospital Wages Decreed in Quebec

The new ordinance of the Quebec Fair Wage Board, setting certain wage levels, will apply to all hospitals in the province with the exception of those in Quebec City and Levis, and with the exception of members of religious orders. It is understood that there are about 12,000 hospital employees in the province, of which approximately 3,000 are exempt as members of religious orders and of which another 2,000 are employed in Quebec City and Levis. All other public and private hospitals are affected. The increases affect all employees earning $50 a month or less. This would apply to about half, or 3,500 of the workers in the affected hospitals.

For those earning between $40 and $50, the increase is 10 per cent; between $30 and $40, it is 15 per cent; between $20 and $30, it is 25 per cent; and for those paid under $20 monthly it is 30 per cent.

Workers earning above $50 get no immediate increase, but the order provides that their wages must be maintained at the present level and that if any such employees are replaced the new workers must receive the same wage as those they replace. Those in this category, however, benefit by the working conditions established.

The ordinance provides that all employees must receive room and board in addition to the wages they are paid. If the hospital does not give the employee a room, it must pay an additional $7 per month, or if it does not provide meals, an additional $13 per month. If neither room nor meals are given, the employee must receive $20 a month in addition to his monthly pay.

Nurses' working shifts are set at 12 hours, figured from 7 o'clock to 7 o'clock, with the following reservations:

Those on day duty get one afternoon, beginning at noon, off each week and a complete day besides every 15 days. They are also to get two hours off each day in addition to one half-hour for each of two meals daily, at noon and at 4.30 p.m. In affect, then, day nurses will have a nine-hour working day less the afternoon off each week and the whole day off every 15 days.

They will be entitled to a week's holiday with pay after six months of service and three weeks with pay after a year's service.

Night nurses will have five hours, from 7 to midnight, off on one evening each week and in addition one whole night off every 15 days. They will also have one hour off each night besides a half hour for one meal at midnight.

Orderlies work the same 12-hour shifts as nurses. Those on duty, however, get a half day off each week, two whole days off at the end of each month and two hours off each day in addition to a half hour for each of two meals. Those on night duty get one whole night off each week and an hour off each night besides a half hour for one meal at midnight.

Both nurses and orderlies, in case of sickness, are entitled to pay for 15 days and free hospitalization in their institutions during that period. This includes doctors' and nurses' care and medicine.

Orderlies are entitled to two weeks holiday with pay after a year's service and also to full time off on two legal holidays of their own choice.

For all other employees, the maximum working hours are fixed at 72 per week. Beyond that they are to be paid at the rate of 50 cents an hour, no matter what their job is.

It is also provided in the Fair Wage Board's order that stationary engineers employed in hospitals are exempt from the new ordinance and are to remain under the provisions of the special ordinance No. 6 which was drafted to apply to them.

The Round Table Forum

2. Should the Press Attend Board Meetings?

Alderman C. M. Fines, Chairman, Board of Management, Regina, Sask.

In a well managed hospital the board need have no fear of accurate reports of board meetings. The public is always ready to believe any gossip about its own institutions. The presence of the press does much to create public confidence in the institution. Otherwise rumours become prevalent and find their way into the press greatly exaggerated.

Certain matters, chiefly disciplinary, might well be discussed in private, by the board meeting as a committee of the whole. There is more to gain than to lose by having the press present at board meetings.

John M. Imrie, Managing Director, Edmonton Journal, Edmonton, Alberta.

It seems to me that publicly owned hospitals are on sound ground in having their board meetings open to the press and through the press to the public, as is the practice of city councils, legislative assemblies, federal Parliament, and other bodies spending public monies.

Voluntary hospitals, operated solely with private funds, are in a somewhat different position. But even in the case of these there is much to be said for having board meeting open to the press. They, also, have some measure of responsibility to the public. Public confidence is more likely to be won by having board meetings open to the press than by having them secret.

J. A. Reid, President, Trustee Board, Victoria Public Hospital, Fredericton, N.B.

There are many problems coming up at hospital meetings that should be considered confidential and it would not be possible to do so if the press were permitted to attend. Matters pertaining sometimes to members of the medical staff, sometimes to members of the nursing staff, etc., have to be discussed, and naturally it would not be in the best interests of all unless they were considered in private.

Mr. James Barnes, Manager, Calgary General Hospital, Calgary, Alta.

Without agreeing that important matters of public interest be suppressed, I believe, that only in the absence of the press does the fullest discussion of certain matters occur, therefore it appears better that the press be absent from the average board meeting.

The press should be given a fair statement, whether it be favourable or unfavourable to those administering an institution, regarding any untoward happenings and should attend those portions of any meeting at which the extension of existing (or the adding of new) services, building programmes, etc., are, after passing their formative stage, up for consideration.

Miss Margaret MacKenzie, President, Board of Commission, Sarnia General Hospital.

I am definitely against this practice. From time to time there are matters of a private nature coming up for discussion at the Board meetings, and in my opinion it would not be ethical to allow the Press to be present on these occasions. I am at all times willing to co-operate with the Press, but I maintain that all information for publication should be given out by the Secretary after the Board meeting, for, however discreet the reporter might be, even he should not know of these private and intimate subjects.

F. I. Ker, Editor, "The Spectator", Hamilton, Ontario.

I should think, on the whole, that from the hospitals' point of view there is more to be gained than lost in permitting the Press to attend board meetings, particularly in provinces where the hospitals are maintained by taxation. Not until hospitals are accepted by the masses in the same calm and matter-of-fact way as they regard schools and other public services will the hospitals, particularly the clinical departments, really come into their own. As a governor of the Hamilton Sanatorium I know how greatly that institution has been helped by the constant publicity which its activities have received from *The Spectator* in the past twenty-five years.

There are, of course, some board meetings which are but remotely a matter of public interest, but that does not alter the fact that the public will feel more reassured and the hospital authorities will be on much safer ground if an unprejudiced and competent observer is present. I don't think board meetings of any kind should be covered by "cub" reporters, and the chairmen of hospital boards would be well advised to request responsible heads of newspapers to assign a regular and competent person to do this work, with the understanding that matters of a delicate nature should be submitted, either to the publishers of the newspapers or to their editors-in-chief.

A Chairman of a Hospital Board who to avoid local controversy prefers to remain anonymous.

My answer is "no". Having had considerable experience over many years in civic matters, I have come to the conclusion that the press should not be permitted to attend as many of the meetings as they now do. The smaller town and city newspapermen are inclined to garble things to suit themselves or certain factions. There are always sore-heads who imagine they have a grudge against the hospital, which upon being traced down are usually found to be due to insistence upon payment of their hospital bill. Such individuals look for and misinterpret any press report of hospital differences.

Question for next month:

"Is a hospital of 40 beds justified in employing a dietitian?"

DALLAS DIARY

By CARL I. FLATH

"WAY down in Texas", the Lone Star State, it is called by some and by others the Empire State because it is the amalgamation of what were at one time five separate sections each with its own flag and own government. It is really a very fine State and Dallas, the "City of Opportunity", is a young, growing, vigorous city, the financial capital of the southwest and the key city of the oil industry and heat. My how disillusioned a lot of Canadians are! You know the picture you would expect to find in Texas; Ten gallon hats, hard riding cowboys, stretching plains covered with roaming herds of steers, and so on. Well, there is none of it and every Canadian here was surprised and disappointed. However, everyone seems to be enjoying the visit here and the fine hospitality of these wonderful southern people. There are nineteen Canadians attending the Convention and we have been treated especially well because we are somewhat of a novelty 'way down here in the southwest. While walking through the exhibit hall today behind Leonard Goudy and Gordon Freisen I overheard two ladies discussing them. The first lady said, "those two gentlemen are from Canada". "Oh", said lady number two, "they don't look like foreigners to me". Canadians at the convention deserving of special mention are Dr. Agnew, the new president of the Association; Dr. MacEachern, a former Canadian who is the king pin of hospital organization work in United States, and Leonard Shaw, formerly superintendent of the Saskatoon City Hospital and editor of the Canadian Hospital, who is now assistant executive secretary of the American Hospital Association. Mr. Shaw's friends will be glad to know that he is making a wonderful success of his new work and has completely sold himself to American hospital people.

HARVEY AGNEW, M.D.

The Commercial and Scientific exhibits are all exceptionally fine. I am sure there is not one item in hospital supplies which is not shown here this year. Some of the exhibits are striking in their originality and not the least interesting display in the exhibit hall is the "On to Toronto" booth which we have maintained for the purpose of creating interest in the Toronto meeting in 1939. Great enthusiasm for the meeting in Toronto is evident everywhere and we are looking forward to a bumper attendance next year.

The following is a summary in diary form of a few high spots of the Convention week:

Monday, September 26th, Temperature 103°

The American Protestant Hospital Association has just concluded its three day session, the Fifth Annual meeting of the American College of Hospital Administrators in session for two days will complete their meetings to-day and the American Hospital Association was formally opened this morning.

Following a dinner meeting last night one hundred and forty-seven new members comprising Fellows, Members and Junior Members were inducted into the American College of Hospital Administrators. Dr. S. S. Goldwater of New York, and Dr. W. S. Rankin of the Duke Endowment of North Carolina were given honorary fellowships and two Canadians, Dr. J. C. Mackenzie of Montreal received his Fellowship and Clarence C. Gibson of Regina General Hospital his Junior Membership in the College. Dr. Goldwater addressed the gathering in his usual spirited manner on the subject of "The Future of Hospital Administration".

This morning at the A.C.H.A. session the question of training for hospital administrators held the stage and during the session an informal announcement of the establishment of Survey Courses in hospital administration in certain key centres throughout Canada and the United States was made. This it is felt will enable those now engaged as administrators as well as department heads to study under competent local leaders a course based on experimental studies now being conducted by the University of Chicago in co-operation with the American Hospital Association. It is hoped that by such studies the senior members of hospital staffs may develop a broader point of view and a greater appreciation of the hospital problem as a whole.

The House of Delegates met for the first time to-day with approximately seventy out of a possible hundred members present. This fine attendance, included in which were several Canadians, and the high degree of interest

Leaves from the Dallas Diary

1. *How to make an exhibit attractive. Even busy Bert Caldwell could not resist the pretty model.*
2. *J. H. Roy, Hôpital St. Luc, Montreal, and Dr. Geo. Stephens, Winnipeg General Hospital.*
3. *Clarence C. Gibson, Regina General Hospital.*
4. *Dr. T. W. Walker, Royal Jubilee Hospital, Victoria, and Dr. Harvey Agnew.*
5. *Dr. M. T. MacEachern, Dr. S. R. D. Hewitt, Gordon Friesen, Miss Pearl Morrison, Dr. Geo. Stephens, Graham Stephens, J. H. Roy, S. S. Cohen, Mrs. Walker, Leonard Goudy, Dr. T. W. Walker, Dr. J. C. Mackenzie, Mrs. Agnew, Dr. T. R. Ponton.*
6. *Alden Mills, Editor Modern Hospital, Dr. J. C. Mackenzie and S. S. Cohen, Montreal.*
7. *Leonard Goudy, Saskatoon, Carl I. Flath, Toronto, and Gordon Friesen, Belleville.*

shown by all delegates would seem to assure the successful future of this new form of legislative organization.

To-night the presidents' session was held under the presidency of Robert E. Neff, F.A.C.H.A. Greetings were received from city and state officials who welcomed the visitors to the city of Dallas and the Lone Star State of Texas. Mr. Neff presented gavels to the presidents of state and provincial associations and following this presentation the National Hospital Day awards were conferred by Albert G. Hahn, chairman of the National Hospital Day Committee. A unique feature of this program was the reproduction of the actual voice of Florence Nightingale from a very early wax record made during her lifetime which had been discovered in London only a few years ago. In this connection it might be mentioned here that the Trustees have authorized a Hospital Day Manual with which it is planned to proceed very soon. Following the President's address the President-Elect, our own Dr. G. Harvey Agnew, of the Department of Hospital Service of the Canadian Medical Association, was introduced and the warmth of his reception indicated the high regard in which he is held by our American co-workers, and they have honoured him by elevating him to the most exalted position in the greatest hospital organization in the world. We Canadians who attended the meeting were thrilled and all hospital workers in Canada can well be proud of his achievement for he will bring nothing but credit to us as hospital people. Dr. Agnew took this opportunity to extend a special invitation to attend the International and American Hospital Association meetings in Toronto, September 19th to 29th, 1939.

A touching tribute to a departed and beloved Canadian hospital worker was the naming of the main auditorium at the Dallas convention the Henry Adams Rowland Hall.

Tuesday, September 27th, Temperature 99°

Under the leadership of S. Frank Roach the section of "Mechanical Divisions of Hospital Operation" was held this morning and a very thorough discussion of the hospital fuel problem as presented by three fuels, oil, hard coal and soft coal was heard. Space does not permit technical review of the subject and as printed reports of these papers will be available in the transactions of the A.H.A., it will be possible for almost everyone to study them in their original detail. A very fine paper dealing with the subject of accidents in hospitals was given at the same meeting and we were advised that in conjunction with the National Safety Council a special cause and prevention study is being developed on this subject.

The Tuberculosis Section included some very important papers dealing with this subject. It was reported at this meeting that an exhaustive Manual dealing with Sanatoria and Tuberculosis care is almost completed and will be made available for distribution by the American Hospital Association. Also it is expected that a study on the Health of Nurses will be published shortly.

The gadget exhibit received special attention to-day and it was extremely interesting to see how original and simple gadgets will solve many perplexing difficulties. Truly in this exhibit the truth of "necessity being the mother of invention" is amply demonstrated. Space will not allow description of the individual gadgets but we must mention that Dr. Geo. Stephens of the Winnipeg General Hospital had three original solutions to old problems and we will endeavour to have him write a story about them in the Canadian Hospital in the near future. Thirty-nine hospitals from twenty-two states and provinces exhibited gadgets, some entrants having as many as five models in the show. This should give our original and resourceful hospital folks something to think about before the convention in Toronto next year. Of all the costly and elaborate displays of merchandise on the exhibit floor there was nothing attracted more attention than the gadget show.

To-night the Alumni of the Institutes for Hospital Administrators 1933-1938 held its Annual Banquet and election of officers. The gathering was addressed briefly by a panel of hospital leaders including Dr. Agnew, Dr. MacEachern, Dr. T. R. Ponton, Leonard Shaw, James Hamilton and others. The following were elected to office for 1939.

Carl I. Flath, Wellesley Hospital, Toronto, Ont., President.

Miss Ruth Wilson, Moncton General Hospital, Moncton, N.B., Secretary.

Miss Helen Branham, Community Hospital, Tupelo, Mississippi, Treasurer.

Wednesday, September 28th, Temperature 101°

The Small Hospital Section held the big interest this morning and subjects included in the session were well chosen and well prepared. "Safeguarding the Patient Against Unnecessary Surgery" and "A Plan to Set Up Reginal Consultation Services" were discussed by Dr. J. J. Galub of New York. The treatment of these subjects provoked new thought on an old problem. Dr. W. B. Caldwell of the Canadian Red Cross Ontario Division, gave a paper on "The Importance of the Small Hospital in Canada". Dr. Caldwell knows his subject thoroughly and his paper was very cordially received. This paper also should appear in a future issue of this Journal. The "Planning and Plant Operation" meeting for 2 p.m. to-day was cancelled because of extreme heat. This was to have included a paper by James Govan, Architect, from Toronto on the "Advantages of Vertical over Horizontal Construction". The other afternoon sessions were not well attended because of the heat.

To-night, however, the Annual Banquet and Ball was held in the air-conditioned ballroom of the Adolphus Hotel. The whole banquet had a Latin American motif. Decorations were Mexican and music during the dinner was furnished by a real Mexican Tipica Orchestra in full costume. Mexican flower girls in full costume circulated among the tables lending a further touch of atmosphere. The address of the evening was given by the Hon. Pat. Neff, President of Baylor University, Dallas, Texas, immediately following which Dr. G. Harvey Agnew was inducted as President of the American Hospital Association. Again a great burst of enthusiastic applause attested his

(Continued on page 78)

Internship and Residency Facilities Under Spot Light

MEDICAL graduates from all over this continent, with a generous proportion from Canada, have gone to New York City to complete their education by internship or residency. Over one-sixth of all the house staff positions in the United States are offered in this city. Therefore the recent survey, completed after four years of study, is of especial concern to all interested in hospital internships and residencies. This study was made by a committee of leading medical educators representing the five medical schools in New York City and the Academy of Medicine and was aided by the Commonwealth Fund.*

This exhaustive report of nearly five hundred pages contains many observations and recommendations, a large number of which are applicable to hospitals and to internships elsewhere.

There is insufficient link-up between the undergraduate courses and the internships. "If their schedules are to be intelligently organized, pains must be taken to integrate them with the undergraduate course." "Except in a few instances the medical schools have had no direct interest in the student after his graduation and they play no role in his subsequent development."

The final test will be whether the training received prepares men to become competent and reliable physicians.

The desirable internship period is two years. There should be six months on medicine and the same on surgery. A desirable arrangement gives two months of gynaecology, three months on paediatrics and from three to six months on obstetrics.

As more special departments are organized, the tendency has been to give interns on a rotating system shorter services and more frequent changes. This is deplored. "There appears to be a direct relationship between the amount of time spent on a service by the intern and the quality of medical standards and teaching."

Some type of "mixed internship", that is one in which the intern spends one or more years on two or three services is recommended. Selective experience seems the soundest educational approach to practice.

All interns should receive basic training in the care of medical and surgical patients.

More than half of the hospitals gave very poor instruction to the interns on their hospital opportunities and duties.

"In general hospitals treating acute conditions, the best quality of medical attention and intern teaching was seen when the case load varied from ten to fifteen patients per house staff member." (Residents included).

Major operative procedures have overshadowed less spectacular phases of the surgical internship in the mind of the intern. The intern on obstetrics has been too much concerned with the case room delivery and not sufficient with antepartum and postpartum care.

"Modern advances in organized record keeping have found their way slowly into our hospitals." On approximately half of the services the quality of medical record keeping by the interns was observed to decline during their hospital service.

"The record committee needs to be educated to the full extent of its responsibility before attempting to initiate the interns."

Neither record committees nor the interns know enough about the use of nomenclatures. Newly arrived interns should be given a formal course in the use of the nomenclature followed.

Well over one-half of the 60 hospitals studied are now using the "Standard Classified Nomenclature of Disease".

Detailed records of the work of the interns were not available. These should be carefully kept.

"Unless library facilities are provided within the hospital, the house staff spends little time in the reading of medical literature."

A record should be kept of the work done, and quality of service given by the interns.*

"One of the most neglected of all phases of intern teaching has been the instruction in such diagnostic and therapeutic methods as venipuncture, paracentesis, spinal tap, and examination of body orifices."

Approximately three-quarters of the interns reported an hour a day as the average time spent in the library.

A *residency* experience of less than two years is an inefficient arrangement both for the hospital and for the educational development of the individual.

In contrast to European centres, the medical staffs in America have shown little interest in physical therapy.

*Internships and Residencies in New York City, 1934-1937. Report by the New York Committee on the Study of Hospital Internships and Residencies. The Commonwealth Fund, New York, 1938.

*Desirable forms for such records are given in the bulletin "Intern Education and Supervision" issued by the Department of Hospital Service of the Canadian Medical Association.

Precaution!—Trial Use of U.S.A. Apparatus

The recent experience of a Canadian hospital, brought to the attention of the Canadian Hospital Council, may have happened to other hospitals. This hospital ordered an expensive piece of clinical apparatus directly from the manufacturer in the United States for a one month's trial only. On arrival they found it necessary to pay the three per cent excise tax, applicable even though the apparatus itself was duty free and, in this case, on trial only. It is our understanding that this excise tax is not refundable upon return of the equipment.

This difficulty could be avoided by ordering the trial equipment from the Canadian agent of the exporting company. The majority of the better known makes of hospital equipment have official Canadian agents who would gladly make these arrangements.

It is well to keep in mind also that, when duty must be paid, the Canadian agent pays it on a smaller invoice as a rule than does the retail consumer. The ultimate cost to the consumer is usually less than by buying directly. At the same time the Canadian dealer also benefits.

Experience with a Central Dressing and Supply Service

REV. SISTER VINCENTIA and
REV. SISTER COLETTE,
St. Michael's Hospital, Toronto

THE Central Dressing Supply Service to furnish dressing trays, solutions, etc., for ward use, was started in our hospital in the fall of 1937. As with all newly established departments, we have been inclined to concentrate on its advantages. On this occasion, however, although complaints never come to the department, or "hardly ever," we shall first mention some *disadvantages* that might obtain.

Possible Disadvantages

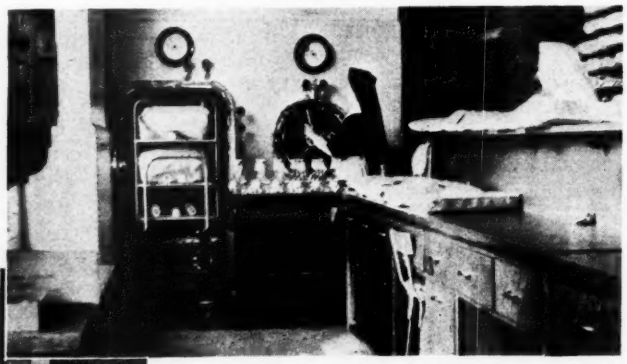
If an intimate relation between the wards and the Central Dressing Service does not exist, it is quite possible that the service may not be satisfactory. However, if it be arranged that suggestions from the chiefs of the departments reach the Central Dressing Service immediately, changes to suit the convenience of those doing dressings can be easily effected. There is such an extraordinary variety in surgical equipment—needles may be mentioned as a particular example—that from the viewpoint of the doctor, and of the intern especially, the standard tray might not be all that he would desire. To have a large assortment, from which he may pick and choose, seems preferable. There are types of dressing trays that are difficult to standardize, and at times a certain amount of duplication does exist. The dressing carriages do supply ample equipment, yet individual trays are frequently requested and issued. This may be only a temporary disadvantage, that we are experiencing during the initial period of our service, and in time the prejudice that some entertain for the dressing carriage, may disappear.

It is noted by the teachers in the training school and by the supervisors that the student nurse has not the same appreciation or even keen interest in the dressing trays that she had when the service was de-centralized. However, this part of her education is given in a more concentrated form during her term in the Central Dressing Service.

Before writing this paper, we conducted a more or less informal questionnaire among the floor supervisors, interns and a few of the staff men. Their immediate response to the question, "Are you pleased that we have adopted the Central Dressing Service in our hospital?" was invariably some expression of unqualified approval, sometimes followed by a suggestion or two regarding some minor adjustment. The psychological effect, of having a carefully supervised and systematized service behind the surgical dressings, is one of immense relief to the floor supervisors. From the viewpoint of economy of time of both the doctor and the nurse, of labour and, above all, economy of supplies, it is evident that this service is invaluable to the hospital.

In our brief experience there is a marked decrease in breakages. Formerly the dressing tray was left in some temporary place until the nurse had time to clean it, or some unwary person upset it. Now it is returned imme-

(Continued on page 46)



Right—All necessary sterilization is done right in the Department.

Left—Ample table space is provided for the setting out of trays.

Experience with a Central Dressing and Supply Service

(Continued from page 44)

diately to the Central Dressing Service for cleansing and replenishment. Loss of equipment has been reduced to a minimum. Deterioration of rubber goods, especially tubing and catheters, due to lack of usage, has been eliminated. All the while the nurse is being taught, informally, desirable habits of exactitude.

The location of the Dressing Service must be central and convenient to the elevators and dumb waiters to ensure rapid service to all the wards. There should be telephone service from the office. The requisition slips, and the duplicates of the cards that are affixed to the trays, should be kept there. These cards register the supplies given out, and they are *an aid* to the nurse in checking the tray before its return.

The supervisor is a graduate nurse, and is assisted by as many graduates and technicians as the work demands. Each week one of the staff accompanies the nurse in charge of dressings on the ward. Since the Central Dressing Service contacts the whole hospital, it is necessary that the members of the staff be individuals who have a sympathetic understanding of the difficulties and emergencies that may arise on the floors. A sense of economy must be tempered by an appreciation of the necessity of having ample supplies. Since faulty technique is so often blamed on instruments, the staff of the Central Dressing Service must be prepared to accept certain criticism which would not ordinarily come from the more experienced.

Section of Central Supply Room.

Some hospitals endeavour to supply almost anything that is required in the nursing care of the sick, except medicines. In our hospital dressing trays of various types and all solutions used for intravenous work are supplied.

Adequate night service may be given by such a department provided an efficient night supervisor has had sufficient training in this department to furnish the equipment or solutions requested.

A.C.S. regional meeting, Toronto, 1938.

Vitamin Products to be Tested by Federal Government

The assay of vitamin products sold in Canada has been undertaken by the Pharmacological Branch of the Laboratory of Hygiene, Department of Pensions and National Health at Ottawa. Determination of the potency of these products is being carried out by methods of biological assay and also, where possible, with physical and chemical methods. The standards used in this work are the International Standards of the League of Nations.

For this work the laboratory space has been extended to accommodate the necessary increase in the number of test animals, as well as the preparation and storage of the special diets. Necessary equipment, such as cages, storage bins, photoelectric colorimeter, and other physical and chemical apparatus have been purchased. The staff has been increased by the addition of a junior pharmacologist and two laborers, who were engaged to carry out the assay work under the supervision of the senior pharmacologist.

In October, 1937, preliminary assays of a number of cod liver oils were commenced. This preliminary work was undertaken to determine the most satisfactory diets and the best methods of selecting animals and recording results. On the basis of the information obtained from this work a number of assays has been carried out on commercial samples.

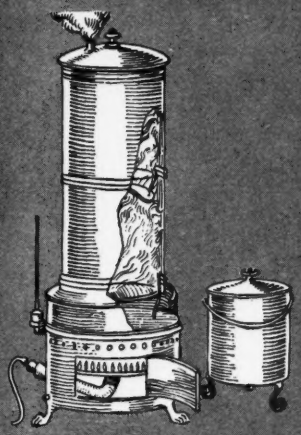
The assays so far completed have dealt with vitamins A and B_1 but an investigation of the vitamin D potency of some commercial products has been started. In addition, the results of biological tests for vitamin A have been checked by means of the colorimeter (photo-electric) and the vitameter.

The materials subjected to test so far have been mostly cod liver oils and their concentrates and vitamin B preparations in the form of concentrates. It was thought advisable to confine the early part of the investigation to medicinal preparations which are widely used. On the basis of information obtained from this survey of products on the Canadian market it is probable that the Department of Pensions and National Health will set up regulations under the Food and Drugs Act governing the potency and labelling of such vitamin products to be sold in this country.

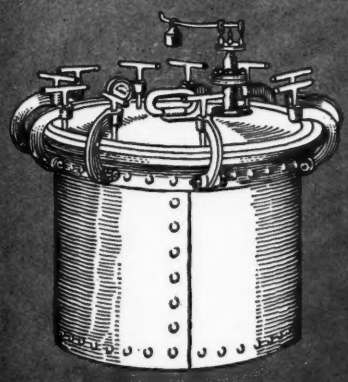
Drumheller Hospital Loses Heavily on Miners' Contract

Auditors employed in the provincial probe into the shortage of funds at the Drumheller Municipal Hospital, Drumheller, Alberta, report a loss of $51,887.04 for the hospital on the miners' contract during the years 1933 to 1937, inclusive. Net cost of operation under the contract for these years was $139,374.79, and amount received from the miners during that period was $87,487.75. Mine workers received a total of 55,562 hospital days in the five-year period at an average daily loss of 93 cents per patient. Actual cost was $14.80 per annum while the rate was only nine dollars. The whole investigation, which was initiated by the hospital board, cannot be completed until certain information is obtained from the Workmen's Compensation Board.

THEN—



THE first steam sterilizer (non-pressure) as designed by Koch and associates.



THE first pressure steam sterilizer of record was built in 1880 by Chamberland for Pasteur's Laboratory.

—NOW

In the Hospital of University of Pennsylvania

*

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PROUD TO SERVE AMERICAN COLLEGE OF SURGEONS

New Curriculum for Nurses Meets General Approval

National Curriculum Committee Makes Report

THE Curriculum Committee of the Canadian Nurses Association, under the chairmanship of Miss Marion Lindeburgh, reported definite progress in its report to the annual Canadian Nurses Association Convention in Halifax this summer. Organized under the Nursing Education Section back in 1932 to construct a curriculum which would serve as a guide for schools of nursing in Canada, this committee has been working for four years with the co-operation of nursing groups throughout Canada. Two years ago, at the meeting in 1936, the proposed curriculum was accepted for trial and experimentation at the biennial meeting in Vancouver. The result of these two years of practical observation are embodied in this report.

Considerable progress is being made in the development of a more suitable national curriculum.

"The proposed curriculum places particular emphasis on the more immediate adjustments which should and could be brought about most easily without much extra administrative or financial pressure. The following are of great importance:

1. An accepted standard of student qualification for entrance to schools of nursing in Canada.

2. A more definite standard of personal and professional qualification for all members of the school of nursing staff, and more adequate provision for professional growth while in service.

3. A better understanding and appreciation of the philosophy underlying the aims of teaching, and supervision.

4. A more carefully organized plan of education whereby preventive, health and curative aspects of nursing may receive appropriate emphasis at every stage of the student's experience.

The Curriculum Committee decided that the proposed plan should be made as flexible as possible; that definite time requirements for effective teaching of various courses should not in the beginning be stated. There has been a prevailing tendency to judge the adequacy of courses by the number of hours assigned to instruction and practice, rather than by the ability of the teacher to teach, by the capacity of the student to learn and apply, by facilities available, and many other factors which make for good educational results. While the Curriculum emphasizes the fact that students should have more time for study and reflective thinking, it does not suggest an increase in the number of courses now undertaken in recognized schools of nursing in Canada. It was the general opinion that fewer and better courses should be recommended and that a definite attempt should be made to re-organize, simplify, co-ordinate and integrate the various phases of theory and practice in the basic course. A study of the Proposed Curriculum reveals the many attempts to achieve this end."

". . . . While it is very evident that there has not been sufficient time since the publication of the Proposed Curriculum to experiment with it fully, many constructive comments have already been made which would improve the arrangement and content of the book. It might be pointed out that the evaluation of returns through the questionnaire method is not an easy task. In many instances, opinions range from the extreme left to the extreme right and a satisfactory middle way must be found; for example, a suggestion is made that Chapters II, III and IV, dealing with Administration, Staff and Students, have little place within the Curriculum report, while others emphasize the fundamental importance of including these chapters. Controversial comments made at this time must be held in reserve for further discussion, and the need of further study of the Proposed Curriculum before a revision is undertaken, is obvious. However, at this beginning stage in the study, the convener is grateful for the opportunity to present to this meeting certain trends of opinion."

Many Comments Received

Miss Lindeburgh reported that general approval of the Proposed Curriculum as a whole had been expressed. The following comments or suggestions were selected as being of particular interest at this time:

"1. The need for a study of the details of the cost of operation of certain selected schools of nursing is suggested, in order that figures may be available to serve as a guide in the more effective administration of all schools of nursing in Canada.

"2. General disapproval of the special university entrance standing termed "Nursing Matriculation", and a suggestion that applicants to schools of nursing should be required to meet the full entrance demands of recognized universities in the several provinces.

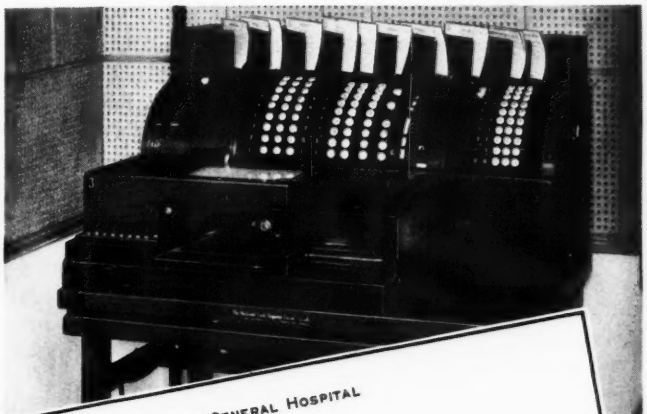
"3. A question as to the possibility of accomplishing the requirements of the Proposed Curriculum within a period of three years, and a suggestion that a first year might be considered to undertake the necessary science subjects (preferably in a university), to be followed by three years in the various nursing subjects and clinical fields.

"4. While general agreement is shown in regard to the personal and professional qualifications of staff members, several suggestions are made which would describe their functions. For instance, more emphasis should be placed upon the classroom teacher having a better understanding of the clinical situation, and the ward supervisor assuming

(Continued on page 50)

NATIONAL

PROVIDES CONTROL OVER REVENUES IN TORONTO GENERAL HOSPITAL



TORONTO GENERAL HOSPITAL

April 9, 1938.

The National Cash Register Company,
467 Bay Street,
Toronto, Ontario.

Dear Sirs:

I would like, at this time, to take the opportunity in expressing our satisfaction in both the operation and need of your Posting Machine in hospital work.

After a thorough investigation and actual demonstration of various machines during the spring of 1930, we were convinced that your machine met with the requirements necessary in our then New Private Patients' Pavilion, - the initial installation of one machine was made. This machine gave perfect satisfaction, providing up-to-date records with the maximum of service to our patients. Following this experience two more Posting Machines have been installed, one for the Public Patients accounts, thus completing the handling of all in-patients accounts in a hospital which has a capacity of over 1,200 beds, - the other machine being placed in the Department of Radiology, and handles all accounts in that Department.

These machines have proved to be simple to operate, notwithstanding the fact that they accumulate all revenues, segregated to give the maximum of information required, control the cash and present a record, in my opinion, second to none.

I would assuredly recommend this system as most modern and complete for all hospitals.

Yours very truly,

R. W. Longmore,
Assistant Superintendent
Administrative.

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New Curriculum for Nurses Meets General Approval

(Continued from page 48)

more responsibility for systematic teaching. It is suggested that the night supervisor should receive more attention in the Curriculum report. The importance of securing a person who really enjoys night service, and whose health remains unaffected, should be included as an added note.

"5. While the qualifications and duties of the head nurse, as described, are approved, the increasing need for recommending special graduate preparation for headnurseship is suggested.

"6. The statement regarding the position and function of general duty nurses as they affect the educational programme, and their influence on the students, should be elaborated to emphasize more forcibly the need of an educational programme for this group, and more interest is to be taken in their professional growth.

"7. A challenging proposal is made regarding the inclusion of communicable disease nursing as a compulsory experience in the basic course. Because of the progress in the field of public health resulting in a great advance in scientific methods of prevention through immunization and other means of control, this should be taken into consideration in constructing a present day nursing curriculum.

"8. Many suggestions as to the re-organization and improvement of the content of the science courses have been offered, also other ways by which these subjects will serve more fully the purpose for which they are intended. Of all the science subjects, chemistry presents the greatest problem. It is suggested that there is really no legitimate place in a nursing curriculum for the teaching of inorganic chemistry. More time could be spent on organic and important phases of physiological chemistry, if the student had preliminary work in chemistry before entering the school. Many helpful ideas have been submitted in connection with the courses in nursing theory and practice. The Curriculum Committee consciously avoided too much description and detail of nursing procedures or techniques, and instead emphasized fundamental principles upon which procedures and treatments should be built up. However, it is the general feeeling that much more detailed content should appear in the nursing courses.

"9. Special mention is made of a small group in British Columbia of experienced public health nurses, social workers and instructors, who submitted a particularly constructive and critical report on the health, preventive and social, aspects of nursing education as outlined in the Proposed Curriculum.

"10. The course outline on mental hygiene and psychiatry, which was prepared by the Canadian National Committee for Mental Hygiene, has received varied comment. The general feeling is that it is too extensive and that it would not be possible for some time to come to secure the practical experience as outlined under adequate teaching and supervisory conditions.

"11. The course in personal hygiene and health education method does not meet with entire approval. The inclusion of a health service and health instruction to meet the individual needs of students is accepted, but the course in principles and methods of health teaching is thought to be beyond the requirements of a basic nursing course.

12. There is considerable confusion as to whether ethics should be reinstated as a regular course with assigned lecture hours, or whether, as proposed in the Curriculum report, it should be handled in a less formal way, achieving the desired ends through informal discussions and conferences and through exposure to a favourable professional environment conducive to the development of ethical ideals and standards of conduct."

Necessity of a Clarified Viewpoint

The report closes with this pointed paragraph. The study and possible application of the Proposed Curriculum would be accomplished more easily if it could be viewed solely from the educational angle, but the complicating factors in connection with the maintenance by the school of a satisfactory hospital nursing service are most distracting and frustrating. All along the way we have confused objectives of hospital nursing service and nursing education, and it is mainly because of this that we cannot as yet see eye to eye. In so many instances, in response to questions asked, replies were prefaced by such terms as the following: '. . . if we could first of all secure an eight hour day for student nurses'; 'if student nurses did not carry such a heavy nursing load'; 'if students could have more time for study'; 'if the wards could be better staffed'; 'if instructors did not have to teach all subjects'; 'if we had better teaching facilities'; 'if head nurses had more time for teaching students'; 'if night nurses did not have to get up for afternoon classes'; 'if the preliminary term could be longer'; and endless other provisos. There are many conditions under the present system which handicap the educational programme, but in the study of the Proposed Curriculum let us focus our attention upon the student and upon the best plan of educational experience that can be provided under existing conditions of hospital control. Our concern is not how well can we fit the student into the scheme of hospital nursing service and the maximum load she can carry over a three year period, but rather what are the potentialities of the student, to what extent can these be developed through effective teaching and nursing practice, and by acquiring the understandings, skills, ideas, ideals and appreciations which will fit her for the general practice of nursing, whether it be in the hospital, the home, or the community."

At the convention it was decided to continue the study and application of a Proposed Curriculum for Schools of Nursing in Canada for another two-year period at least.

The following resolution respecting the relationship of the eight-hour day to the Proposed Curriculum was adopted:

WHEREAS the present long hours of service rendered by student nurses seriously interfere with the implementing of the recommendations of the Proposed Curriculum for Schools of Nursing in Canada. Therefore, Be it Resolved, That a Committee of the Canadian Nurses Association be formed with provincial representation to proceed with definite plans to secure an eight-hour duty period for student nurses, this to apply to night as well as day duty; also, that this same committee take steps to implement and bring into force an eight-hour day for graduate registered nurses.

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Simpson's

Illustrated is one of the private rooms in the new private pavilion of Hotel Dieu Hospital, Windsor—one of Simpson's most recently completed jobs. St. Joseph's Hospital, Parry Sound, and the new wing of St. Michael's Hospital, Toronto, are two more undertakings completed by Simpson's this year.

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PROGRAMME

Ontario Hospital Association Convention

Royal York Hotel, Toronto, November 1st, 2nd and 3rd

First Day, Tuesday, November 1st

Morning Session

9.00 a.m.—10.30 a.m.—Registration.

10.30 a.m.—Report of Secretary-Treasurer: Dr. Fred W. Routley.

10.45 a.m.—Appointment of Nominating Committee.

11.00 a.m.—Official Opening of Exhibits:

(a) "O Canada".

(b) Opening of Exhibits by President of Association.

(c) Reply by representative of Exhibitors.

(d) God Save the King.

12.30 p.m.—Luncheon: Speaker, Dr. Malcolm T. McEachern, Associate Director of the American College of Surgeons.

Afternoon Session

Chairman, Miss Ella MacLean.

2.30 p.m.—Open Session: conducted by Nurses' Section.

—Dr. Smirle Lawson, Chief Coroner of the City of Toronto and Supervising coroner of the Province of Ontario, "Points of Importance in doing Medical Legal Autopsies". Discussion.

—Moving Picture: "Through the Years with a Pupil Nurse". Produced by The Toronto Western Hospital.

Evening Session

—Meetings of Sections.

Second Day, Wednesday, November 2nd, 1938

Morning Session

—Programme arranged by Women's Hospital Aids Association, Province of Ontario. Chairman: Dr. Malcolm T. McEachern, President, International Hospital Association.

9.30 a.m.—"Medical Social Work as a Vital Health Service", Miss J. M. Kniseley, Director of Social Service, Toronto General Hospital.

10.00 a.m.—"What experience has taught in the Operation of a Convalescent Hospital", Reverend Sister Beatrice S.S., J.D., Superintendent, St. John's Convalescent Hospital, Newtonbrook.

10.30 a.m.—"Understanding the Chronically Ill", Miss Merle Watson, R.N., late of the Sudan Interior Mission, Superintendent, St. Peter's Infirmary, Hamilton. Discussion led by Dr. Malcolm McEachern.

Afternoon Session

—Chairman: Mr. David Williams, Trustees' Section.

2.30 p.m.—"Medical Records", Dr. G. Harvey Agnew, Secretary - Treasurer Canadian Hospital Council.

3.00 p.m.—"Questions Regarding the Ontario Government Regulations Relating to Hospitals", Dr. B. T. McGhie, Deputy Minister of Hospitals for the Province of Ontario.

3.30 p.m.—"Problems Connected with Medical Interns", Dr. S. Ryerson, Assistant Dean, Faculty of Medicine, University of Toronto.

—Round Table: Discussion opened by Dr. A. H. Sellers, Medical Statistician, Department of Health of the Province of Ontario.

Evening Session

6.45 p.m.—Annual Banquet: President's Address.

—Address: The Honourable Harold J. Kirby, Minister of Health of the Province of Ontario.

—Address of Welcome: His Worship, Mayor Day.

—Entertainment: Mr. Frank Oldfield; Stanley St. John's Orchestra; Dance at conclusion of Banquet.

Third Day, Thursday, November 3rd, 1938

Morning Session

—Chairman: Mr. A. J. Swanson, President.

—Dr. J. A. Hannah: "Medical Services Incorporated".

—Round Table: "Common Problems of Administration".

Afternoon Session

—Chairman: Mr. A. J. Swanson, President.

2.30 p.m.—Reports of Sections:

(a) United Hospital Aids, Mrs. O. W. Rhynas.

(b) Trustees Section, Mr. David Williams.

(c) Nurses Section, Miss E. MacLean.

(d) Record Librarians Section, Miss I. Marshall.

(e) Social Service Section, Miss J. M. Kniseley.

—Reports of Committees:

(a) Legislation, Dr. John Ferguson.

—General Business.

—Discussion.

* * *

ASSOCIATION OF RECORD LIBRARIANS OF ONTARIO

Dining Room 10, Mezzanine Floor

Tuesday, November 1st

9.15 a.m.—10.00 a.m.—Registration.

10.00 a.m.—12.30 a.m.—General Session: Miss E. M. McKee, Superintendent Brantford General Hospital, presiding.

—Presidential Address: Miss Isobell Marshall, Brantford General Hospital.

Address: "The Organization and Management of a Medical Record Department", Sister Mary Paul, St. Michael's Hospital, Toronto.

—Round Table Discussion on Medical Records.

(Continued on page 72)

Ontario Hospital Association News

Mr. R. Y. Eaton is reported to have donated a modern operating table to the Red Cross Memorial Hospital, Durham.

Angus McIntosh, Montreal grocery importer, former patient at Homewood Sanitarium, Guelph, announced in Hamilton on September 12th, that he had received a request to inspect the famous Hartford retreat at Hartford, Conn., and that if he is satisfied that it is the type of mental retreat he is led to believe, he will build, at his own expense, a similar hospital in Ontario, and hand it over to the government.

Sister Gerard, Reg. N., for a number of years in charge of the operating room at St. Joseph's Hospital, has been named superior of St. Mary's Hospital, Kitchener, in succession to Sister Helen, who has been given new duties at the House of Providence in Dundas.

It is reported that the men's and women's dormitories and the huge dining hall of the new mental hospital near St. Thomas will be ready for occupancy in approximately four months.

Complete abandonment of the Ontario Hospital at London, housing 1,600 mental patients, was recommended by R. A. McAllister, Deputy Minister of Public Work, before the Hepburn-appointed Royal Commission inquiry into publicly administered mental institutions of Ontario. Mr. McAllister felt the building was unfit for use.

A grant of $100,000 is being sought by the City Council, London, Ont., from Middlesex County toward capital expenditures for Victoria Hospital, it is reported.

Miss M. Ruth Cameron, superintendent of the Isolation Hospital, Fort William, for the past year, has tendered her resignation, as she plans to go east to take a course in public health nursing. Resignation became effective September 23rd.

New X-ray equipment is to be purchased for the Louise Marshall Hospital, Mount Forest.

A new wing, dedicated to the late Dr. Peter McGibbon, was recently opened at the Bracebridge Red Cross Hospital.

The "iron lung" provided by the generosity of the people of Stratford was received at the Stratford General Hospital on Sept. 6th.

The new Essex County Sanatorium building is nearing completion and should be open around the first of next year, it is reported.

Hamilton General Hospital will receive $8,000 from the provincial government for extension of its cancer clinic, it was announced on August 21st.

The Bruce County General Hospital at Walkerton is to benefit to the extent of $7,000 through the estate of the late Mr. Valentine Fischer.

Instructions to prepare sketches for a $500,000 unit for Victoria Hospital, London, which would be the nucleus for an all new hospital have been issued to Watt & Blackwell and O. Roy Moore, joint architects.

Dr. A. T. Gillespie of Fort William, was re-elected district counsellor of the Ontario Medical Association at the annual district meeting on August 20th.

John Labatt, Limited, London brewers, have notified all of their full-time employees that the Company would assume the cost of employees' hospital expenses. In brief, each man receives an allowance every day he is confined to any licensed hospital for sickness and off-the-job accidents, as well as certain indemnities for use of operating room, anaesthetics, etc. The plan has been adopted without cost to the employee, to supplement the contributory Group Life and Sickness and Accident Insurance which the employees have enjoyed for a number of years.

—F. W. Routley, M.D.

WOMEN'S HOSPITAL AIDS ASSOCIATION
Province of Ontario, Canada

The Women's Hospital Auxiliary to the Nicholls Hospital, Peterborough, held its first annual meeting on the evening of September the nineteenth, when gratifying reports were presented revealing the fact that extraordinarily good work had been done by this new organization; over two thousand dollars being earned by the energetic groups during that time and fifty life memberships having been received. This organization has a group in every church, the Salvation Army included. Much social service work and visitations being also recorded. The membership comprising home and active members has reached the splendid number of two thousand.

During the meeting the chairman of the Hospital Board and the superintendent spoke in high terms of praise for the work accomplished and said that the co-operation during the year had been exceedingly fine. The Provincial President gave an inspirational address after the business session closed and spoke in complimentary terms of the fine co-operative spirit so evident among chairman of the Board, Superintendent and the Aid.

Many of the Hospital Aid groups at this season are planning membership campaign drives. This phase of Hospital Aid activity is more important than the casual observer might think.

As each new membership welds one more link in the chain of friendliness and understanding of the hospital in the community, the act of becoming a hospital aid member whether active or home helper drops the little seed of desire to know better the needs of this necessary and benevolent institution.

It is difficult to measure just how far the benefit goes in acquiring these contacts through memberships. Each membership received is just one more better understanding and realization that the hospital needs us and our support just as every home in the community at some time or another needs the hospital.

—Margaret Rhynas.

FOR THE *Surgery* .

Modern electric sterilizers provide accurate control of the sterilizing process with complete safety and convenience. Automatic features insure positive surgical sterilization with economical use of current.

● *Electric autoclave, equipped with high efficiency electrical heating assembly with protective cutout, dual automatic heat control, thermometer, automatic air and condensation ejector.*

. . . AND THE *Utility Ro*

Modern sanitary apparatus for emptying, washing and sterilizing bedpans and urinals, improves routines, insures proper care of these utensils, saves nurses' time and energy.

Scanlan-Morris equipment will be shown at the Ontario Hospital Convention, Royal York Hotel, Toronto, November 1-3, in the J. F. Hartz Company's Exhibit Booth.

APPROVED — AMERICAN COLLEGE OF SURGEONS

● *A458 free-standing bedpan apparatus, especially suitable when replacing old style fixtures.*

SCANLAN-MORRIS COMPANY

Hospital Equipment and Sterilizing Apparatus

MADISON, WISCONSIN

OPERAY LABORATORIES, Surgical Lights

SCANLAN LABORATORIES, INC., Surgical Sutures

Here and There in the Hospital Field

By THE EDITOR

A coroner's jury in Brantford has made a pertinent suggestion. It is recommended "that the hospital should be notified by the Fire Department when the ambulance is sent out on an accident case so that the emergency ward can be adequately prepared to handle victims". Evidence was given to the effect that there was a lack of first aid at the scene of the accident and in the ambulance, and that nurses and house doctors had to be summoned at the hospital. In this particular case a severed cartoid artery and jugular vein gave little time for successful treatment and the patient died just after reaching the hospital. Naturally a hospital cannot be expected to have the room prepared and a staff waiting if it has not been given adequate notice.

* * *

A feature of the new Jessop Hospital for Women at Sheffield, England, is worthy of serious consideration. There is a large proportion of single rooms for the obstetrical patients. Each patient, after passing through the admission unit, will be given one of these private rooms, where she will remain for five or six days after the birth of her baby. For the remainder of her stay—and they try to keep all mothers fourteen days at this hospital—she will be accommodated in one of the general wards, none of which will contain more than six beds. Patients who have not "booked" and passed through the antenatal department, will be accommodated on a separate floor and will remain in single rooms throughout their stay. The labour rooms are so arranged that one or more can be shut off completely as a separate unit in case of infection or for emergency.

* * *

Hospitals which, on occasion, require a guarantee from a third party for the cost of hospitalization of a patient will be interested in a decision given at the Ilford County Court in England. A father signed a guarantee in respect of hospital care given to his son by the King George Hospital at Ilford. Five weeks later the son was discharged as improved, but was re-admitted a fortnight later and subsequently died. The first account was paid, but the hospital sued for a portion of the second account. The verdict was against the hospital, as the guarantee was held to apply only to the first admission, inasmuch as in this case the departure was not intentionally of a temporary nature. In the circumstances, the defendant could only be made liable as guarantor in respect of the second stay of the patient in the hospital if another guarantee in writing had been signed. By inference, a fresh guarantee should be obtained on every re-admission of a paying patient for whom there is a guarantor.

* * *

Unannounced, a patient evidently in need of medical assistance, presented herself at the entrance of the emergency wing of the Toronto General Hospital. When examined by one of the interns, she was unable to give her name and address, but was so obviously in need of attention that the intern decided to admit her at once. Accordingly, she was admitted to a box cubicle in a warm corner of the hospital greenhouse, from whence the latest bulletins would indicate that both mother and kittens are doing as well as could be expected.

* * *

London, Ontario. That centre of controversy, municipally controlled Victoria Hospital in London, is again very much in the limelight. The necessity of a modern plant for this university centre has been recognized for years and surveys have been made, a number of plans have

been proposed and on one occasion a considerable sum of money was collected. More recently, with other funds available, the Trust has been busily engaged, in co-operation with the university, in re-planning the much needed additions. The latest move, however, has been the action of the City Council's special committee in taking the plans for the new buildings out of the hands of the hospital authorities, who has placed the preparation of the plans with a joint committee representing the City Council, the Hospital Trust, the University, the medical staff and the Meek Fund. However, this controversy over direct city control of the hospital may result, it is stated, in the loss of the $100,000 grant from the government, which was really given to the University for medical teaching, and the $100,000 from the Meek Fund which was given not to the city but to the University and the Hospital for instructional purposes. Meanwhile *tempus fugit*.

* * *

It was an inspiration to visit St. Michael's Hospital in Toronto during its "clinical week" and see the enthusiasm engendered among the visitors, the staff and the Sisters. All together there were nearly 200 doctors registered from out of town points. This was exclusive of the many Toronto practitioners who registered. The admirable program which filled the entire day from nine to five was provided and there were many scientific and commercial exhibits along the corridors of the convention floor. The unusually fine loose-leaf notebook given to each registrant was unique in that a synopsis of each lecture was printed on a portion of each page and the remainder of the page was blank for notes. All in all, the clinical week did great credit to the efforts of a Canadian hospital. When asked the secret of such successful arrangements, the Sisters and staff agreed that the primary requisite was to have available the services of an energetic chairman like Dr. Harry G. Hall.

* * *

We regret to learn of the illness of Dr. Hugh Mitchell, Superintendent of the Regina General Hospital. The direction of this hospital is, by no means, the easiest task in the world, and the strain of maintaining this institution at its high degree of efficiency has taken its toll. We wish Dr. Mitchell an early and complete recovery.

* * *

It is of more than passing interest, in view of the rapid growth of community-sponsored non-profit hospital service plans, that such have received support of private insurance companies. It would appear that these plans do not infringe, to any appreciable extent, upon the field of the private companies. Dr. Rorem made the statement that more than fifty of the largest insurance companies in the United States have actively supported the movement and entered their home and branch office employees in local non-profit hospital service associations.

The town of Wynyard and municipalities of Big Quill and Elfros, Saskatchewan, are considering a $40,000 government loan for the erection of a 20-bed hospital, which after erection would be taken over by the Grey Nuns

The Present Status of Sales Tax Exemption On Building Materials

Situation Clarified by Ottawa Rulings

THERE has been some uncertainty concerning the effect of the 1938 amendments to the sales tax legislation upon the arrangement for the exemption from sales tax on building materials used in hospital construction. Hitherto, it has been necessary for hospitals to make arrangements to purchase building materials themselves, in order to qualify for the sales tax exemption. It has not been clear to a number of hospital architects and building committees whether, under the new arrangements, the public hospitals would be able to obtain full sales tax exemption, irrespective of how the contract is let, or whether they would obtain exemption only on the materials mentioned in the rulings should they permit the contractor to purchase the materials. An interpretation was requested of the Excise Division of the Department of National Revenue and the following information was received:

"The 1938 budget changes, insofar as building materials are concerned, may briefly be cited as follows:

"The following materials are specifically exempted from sales tax, *irrespective of the status of the purchaser;*

Bricks, building tile, building blocks and building stone;
Plaster, lime, cement, stucco and stucco dash;
Lumber, sash, doors, shingles, lath, siding, stairways, balustrades, paints, varnishes, white lead and paint oil;
Prepared roofing;
Shower baths, bathtubs, basins, faucets, closets, lavatories, sinks and laundry tubs;
Builders' hardware, viz.: Locks, lock sets, butts, hinges, pulleys, window fasteners.

"The following articles and materials are exempt from sales tax when for the specific use mentioned after each item:

"Building contractors could purchase these materials from the manufacturers thereof by giving a certificate to the manufacturer that the goods were to be used for the purpose stated in the exemption:

Plaster boards, fibre boards, wallpaper, building paper, and materials manufactured wholly or in part of vegetable or mineral fibre for wall coverings or building insulation;
Glass for buildings;
Furnaces for heating buildings;
Structural steel to be used exclusively for the framework and support of buildings.

"Materials other than those covered by the two classifications above are taxable as heretofore unless, of course, they are purchased by the hospital itself, in which case the certificate to be given by the hospital to the supplier is to the effect that the articles or materials being purchased are for the sole use of the hospital (naming it) and are not in any case for resale. This, of course, is the regular form of certificate used on hospital purchases and quoted in Circular No. 707-C Revised.

"The exemptions referred to above apply either in the case of new buildings or new wings being added to existing buildings.

"You understand, of course, that in the case of the construction of a new hospital the materials not covered by the specific or conditional exemptions referred to above would be taxable until the hospital obtains certification by the Department of Pensions and National Health."

Purchases by Hospital Less Confusing

It would appear from this interpretation that were contractors to purchase the exempted material and articles, it would seem to be necessary, in order to obtain the sales tax exemption, for the hospital to purchase materials not listed as exempted. As a combination of these two arrangements would cause endless confusion and book-keeping, it is obvious that the simplest and most satisfactory arrangement would be to have the contractor take on the job on a fee basis or a similar basis and have all of the material purchased in the name of the hospital.

Exemption Classification of Building Materials

The Canadian Hospital Council referred this matter to Mr. J. Clark Reilly of Ottawa, General Manager of the Canadian Construction Association. It was his opinion and that of their president, Mr. C. D. Harrington, that the hospitals would be well advised to follow the procedure which they have been doing previously, namely, to have the contractor make the purchases on forms bearing the name of the hospital.

The Excise Division of the Department of National Revenue has issued two Sales Tax Bulletins, listing exemption and taxable materials and equipment under different headings. There are combined in the following list for purposes of ready reference:

Bricks, Building Tile, Building Blocks, Building Stone, Plaster, Lime, Cement, Stucco, Stucco Dash

Exempt	Taxable
Floor and wall tile;	Terrazzo;
Crushed marble stucco dash;	Marble chips;
Crushed stone for construction of buildings only;	Plaster of Paris;
Hard wall plaster;	Dental plaster;
Artificial stone;	Marble;
Cement blocks;	Dental cement, china cement and other similar cements;
Granite for buildings;	Crushed stone for wharves, piers, etc.;
Marble trim for buildings, i.e., baseboard, wainscot and similar items.	Linoleum tile flooring;
Note: The exemption does not extend to soda fountains, marble counters or marble furnishings of a building.	Asphalt tile flooring;
Cement;	Mosaic (wood) flooring;
Note: The exemption for cement refers only to Portland cement.	Parquetry or parquet flooring;
Gauging plaster.	Stove cement;
	Bowling alleys.

Lumber, Sash, Doors, Shingles, Lath, Siding, Stairways, Balustrades

Exempt	Taxable
Metal stairs, balustrades and doors; Creosoted lumber; Metal lath, metal shingles; Metal sash and metal doors; Metal siding; Metal window frames; Veneers; Plywood; Mine timber; Squared timber; Sash and door frames (wood); Hot bed sashes; Vault doors; Cold storage doors; Screen doors.	Fire escapes; Ornamental iron work, such as balconies, decorative ornamental iron trimmings and grill work, cashiers' cages, etc.; Venetian blinds; Furniture, boxes, counters, manufactured cabinets and display cases whether assembled or knocked down; Railroad ties, switch ties; Metal and wooden partitions; Picture frames; Crates; Metal door frames; Window screens; Window screening; Cross arms for telegraph and telephone; Shims; Weatherstrip of all kinds;

Plaster Boards, Fibre Boards, Wallpaper, Building Paper and Materials Manufactured Wholly or in Part of Vegetable or Mineral Fibre for Wall Coverings or Building Insulation

Exempt	Taxable
Sea grass; Insulating boards, such as beaver board, ten/test, bishopric and the like; All roll or blanket insulation regardless of its composition; this includes sea grass, eel grass, spaghnum, etc.; Cork, whether in sheets or ground; Rock wall; Spun glass; Decorative wall paper; Rock wool.	Tar or asphalt used for damp proofing foundations; Oilcloth such as is used for tables even though it may be advertised as wall covering.

Paints, Varnishes, White Lead and Paint Oil

Exempt	Taxable
Dry colours; Colours in oil; Shellac; Duco and dulux; Lacquers; Japans; Stains; Fillers (for brushing); White lead, red lead, green lead; Shingle stain; Linseed oil and soya bean oil when for use as a paint oil; Calsomine; Alabastine; Cold water paint; Synthetic enamels; Bronze powder.	Caulking material; Wood fillers; Plastic wood; Bitumen; Asphalt; Coal tar; Turpentine; Acetone; Floor wax; Putty; Paint and varnish removers; Coal tar, pine tar; Pumice, rotten stone; Sandpaper; Glue; Neatsfoot oil; Stove lining, stove cement; Gold, aluminum or silver leaf; Shellac gum; Solvents and driers for paint, enamel or varnish; All driers for paints, Japans, lacquers, etc.; Wall size; Wall size glue; Floor wax; Putty; All bituminous, asphalt or coal tar protective coverings;

Exempt	Taxable
	Asphalt, asphaltum, bituminous pitch or coal tar plastic products used as roofing;
	Fillers, caulking material, damp proofing, water proofing, etc., whether called cements, paints, roofing, or by any other designation.

Prepared Roofing

Exempt	Taxable
Metal roofing manufactured especially for and sold as roofing;	Roofing nails;
Corrugated iron roofing;	Ventilators;
Flashings, valleys, hips, ridge caps, hip caps, plain and drip starters;	Roof lights, skylights;
Galvanized clapboard siding;	Weather vanes;
Clapboard and other corner cap;	Well curbing;
Metallic Spanish tiles;	Metal culverts;
Metallic ceilings;	Metallic cornices;
Metallic siding;	Metallic coping;
Metallic moulding;	Metal partitions;
Metal lath;	Eave trough;
Corner bead.	Down pipe;
	Conductor pipe;
	Elbows, shoes, rain water cut-offs, and all similar eave troughing materials and parts;
	Asphalt, asphaltum, bituminous, pitch or coal tar plastic products used as roofing.

Shower Baths, Bath Tubs, Basins, Faucets, Closets, Lavatories, Sinks, and Laundry Tubs, not including Pipes or Pipe Fittings

Exempt	Taxable
Shower baths (complete);	Movable hand wash basins;
Combination faucets;	Closet seats, closet tanks and closet bowls—when sold separately;
	Soil pipe and fittings therefor;
	"Roughing in" materials;
	Soap receptacles, towel bars, glass receptacles, tooth brush and glass holders, bath handrail; all the foregoing whether built into the wall or sold separately.

The exemption referred to governs the items by themselves when sold complete. It does not extend to parts either for repair or when sold separately as, for example, you will note in the case of closets that the unit must be sold complete in order to obtain exemption. The several items comprising a closet when sold separately are taxable.

Glass for Buildings

Exempt	Taxable
Window, door and partition glass whether plain, leaded or having a metal screen incorporated into it;	Glass for counters and panels;
Plate glass and window glass for store fronts.	Base board trim;
	Glass electrical fixtures;
	Mirrors.

Furnaces for Heating Buildings

Exempt	Taxable
Hot water and steam boilers for coal, gas or oil used for heating a building.	Steam valves;
Note: This does not include boilers for maintaining the hot water supply for other purposes than heating in the building.	Gauges;
	Blow-off valves;
	Water columns;
	Pipe or pipe fittings;
	Piping and control apparatus;
	Air conditioning equipment for furnaces:
	Pipes, ducts, warm air registers, galvanized furnace casings, furnace controls;
	Radiators;
	Oil burners;
	Blowers;
	Fans;
	Control apparatus for all the foregoing;
	Range boilers;
	Hot water heaters;
	Water softeners, whether systems, stoves, ranges or heaters;
	High temperature insulation for use outside of furnaces;
	Mineral wool for insulating hot water boilers or furnaces;
	Insulation materials for hot air or hot water pipes;
	Pipe coverings;
	Automatic oil or gas water heaters;
	Water heating units for installation in furnaces but not sold as a part thereof;
	Tobacco curing furnaces;
	Steel smelting furnaces;
	Other furnaces for heating products during the course of manufacture;
The furnace proper not to include—	
Note: (Where a furnace is sold with casing, the whole unit is exempt.)	

The exemption for furnaces, as explained above, covers the furnace proper when sold as a unit.

The exemption does not extend to furnaces or boiler parts or repair parts of any kind.

Builders' Hardware, Namely: Locks, Lock Sets, Butts, Hinges, Pulleys and Window Fasteners

Exempt	Taxable
Door lock;	Padlocks;
Sash pulleys, including the sash weight;	Awning Pulleys;
Butts: all kinds;	Bars: Push;
Deadlocks: Mortise;	Guard;
Cylinder Rim;	Closet.
Fasteners: Casement (not to include bolts);	Bells: Door;
Sash.	Door bell sets.
Hinges: Door;	Bolts: Barrel;
Double-acting floor spring;	Bookcase;
Lavatory spring;	Chain;
Strap;	Cremone;
Tee.	Extension flush;
Latches: Cylinder rim night;	Flush;
Mortise night.	Foot;
Mortise knob latch sets.	Lavatory;
Locks: Garage door;	Mortise;
Bathroom;	Spring window;
Bit key and cylinder;	Surface.
Sliding door.	Brackets: Pole.
Locksets;	Brass Corners.
Pulleys: Sash.	Buttons: Electric push;
	Cupboard.
	Catches: Cabinet;
	Cupboard;
	Friction;
	Miscellaneous;
	Screen door;
	Transom.
	Card Holders and Pulls;
	Casement Adjusters;
	Casters: all kinds;
	Complete Cylinders;
	Drawer Pulls;
	Door: Checks;
	Closers;
	Holders;
	Knobs;
	Knob roses;
	Knockers;

Exempt	Taxable
	Pulls;
	Stops;
	Stops and Holders.
	Fasteners: Chain door;
	Shutter.
	Handles: Drop;
	Flush Cup;
	Lever.
	Hasps: Hinge .
	Holders: Card;
	Door;
	Garage door.
	Hooks: Cabin;
	Ceiling;
	Coat;
	Hat;
	Lavatory;
	Pole;
	Towel;
	Wardrobe;
	Hooks and Eyes;
	Hinges: Box;
	Cabinet;
	Chest;
	Cupboard;
	Wardrobe;
	House numbers;
	Key Blanks;
	Escutcheons.
	Knobs: Cabinet;
	Door;
	Drawer;
	Shutter;
	Thumb.
	Latches: Mortise knob;
	Mortise sliding door;
	Mortise store door;
	Rim knob;
	Screen door;

(Continued on page 65)

Panel Heating for Hospitals*

Summary of an investigation on behalf of
The Central Bureau of Hospital Information (London) and
The Invisible Panel Warming Association

By HAROLD E. TEMPLE, M. Inst.Fuel, M.I. Chem.E., F.C.S.

Note: Panel heating has been taken up much more extensively in Great Britain than on this continent, although considerable research is now going on in Cincinnati and other centres. Panel heating was installed in 1933 and again in 1935 in the Mertopolitan State Hospital in Waltham, Mass. The principle involves the use of heating panels embeddel in the ceiling or walls and through which warm water circulates, heat being disseminated by radiation alone, as with a fireplace, rather than by convection, as in the case of hot air heating, or by convection plus a certain amount of radiation, as in the case of hot water or steam heating. It should not be confused with the fad of concealing radiators behind plaster panels or enclosing them in decorative cases which merely eliminate radiation and interfere with convection.

It is generally recognized that panel heating permits comfort at a room temperature quite a few degrees below the standard requirement of 69° F. This timely report, based upon the actual experience of 42 hospitals of varying size and type, answers many questions relative to the advantages and the costs of maintenance of the low temperature (120° F.) embedded system of panel heating as compared to radiator heating. On the whole it is quite favourable. However from the viewpoint of our Canadian climate, evidence is not adeqate that the system would permit prompt enough response to our more sudden temperature changes.—*Editor.*

The investigation deals first with certain objections against the use of embedded panels, namely:

(1) The liability to cracking of the plaster;

(2) The difficulty of locating and repairing leaks if they occur;

(3) The damage caused by such leaks;

(4) The sluggishness of operation.

In the majority of buildings visited no cracks at all were visible. In certain instances cracks were discovered by close scrutiny, but these were confined to the skin of paint or distemper arising generally from the use of unsuitable materials. In all the hospitals visited no repairs of any kind had been required to any embedded panels or steel piping, nor had any leaks occurred. Neither is there any reason, in the embedded panel system to anticipate failure through external or internal corrosion or obstruction from deposits in the pipes. Internal deposits are not a serious factor where there is no evaporation or replacement of water. In certain circumstances the time lag of the warming effect from embedded panels is greater than that from a radiator system. There is no inconvenience, however, when proper circulating temperatures in relation to the requirements are maintained.

General Observations

Definite advantages of the low temperature embedded panel system which were generally conceded are:

(a) Floor and wall space are left free and interference with the mobility of beds and fittings does not occur;

(b) Less labour is required to keep equipment clean;

(c) With the ceiling system, there is regular distribution of warmth and no obstruction of radiant effect by furniture, as in the case of wall panels;

(d) Less risk of cross infection by convection currents;

(e) Complete absence of heated surfaces on which dust can settle eliminates conditions favourable to the propogation of germs;

(f) Absence of rapid convection currents gives freedom from blackened walls and ceilings and prevents the dissemination of dust;

(g) A high standard of comfort can be maintained at comparatively lower air temperatures;

(h) Low temperature rays from ceiling panels warm the occupants directly. The air is not dried by contact with highly heated surfaces, therefore the respiratory passages are less likely to be irritated;

(i) With low temperature radiant warming, natural ventilation (through the skin) can take place freely without discomfort.

One advantage claimed for radiators is that they may serve a drying and warming convenience, but it is to be remembered that by such use the efficiency of the equipment as a heating unit is lessened; this practice in the wards is not a desirable one.

Though definite evidence on the rate of recovery of patients was not available, the opinion is held by many that the absence of rapid convection currents is beneficial. No surgeons complained of any discomfort in the operating room from the downward radiation.

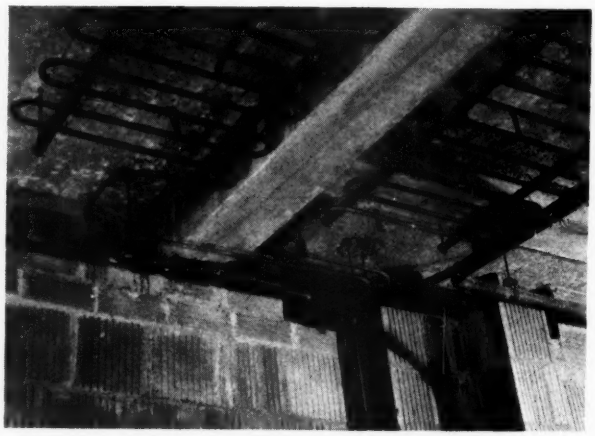
Strict adherence to the recommendation of the specialists in invisible embedded panel warming and careful attention to the method of operating heating installations must be observed if full benefit is to be derived from the installation. Several doubtful points have been cleared up by this investigation, e.g., it has been found that the difference in warming effect between ceilings of 10 ft. and 25 ft. is practically inappreciable; cross ventilation through a ward has no effect on warming rays emanating from ceilings although air currents should not be directed on to the warmed portion of the ceiling as this tends to reduce efficiency by lowering the temperature of the radiant surface;

(Continued on page 64)

*Invisible Embedded Panel Warming System for Hospitals by Harold E. Temple, M.I.F., M.I., Chem. E., F.C.S., Preface by R.H.P. Orde, O.B.E., B.A., Central Bureau of Hospital Information. (London.)

adequate thermal insulation is important in flat roofs and its lack will result in considerable heat losses; *ceiling panels* are preferable to wall panels since there is no obstruction to the regular and equal distribution of the radiated warmth, and the pronounced convection currents initiated by the heated walls are avoided with the consequent absence of deposited dirt.

The 42 hospitals inspected represented all classes of institutions, and replies were given by medical and administrative heads, engineers, matrons and sisters. Twenty-three of these hospitals used the system throughout the whole building (though other systems of warming may have been used in certain rooms); nine used it in wards, private rooms and general services only; eight in operating theatres only; one in out-patients' department only; and one in nurses' home only. Installation and subsequent additions dated from 1926 to 1937. The ratio of position was 28 in ceilings, 10 in ceilings and walls, and 4 in walls only.



Before the Coils are Embedded.

Methods of generating heat were: direct gravity circulation from boiler; pump assisted circulation from boiler; through calorifier heater by hot water; and through calorifier heater by steam—the latter being the most popular. Forms of calorifier or boiler control include: thermostat control on boiler; automatic damper control on boiler; thermostat on calorifier (most in use); and hand control. In most cases the room temperature was regulated by hand operated valves generally placed in accessible wall boxes. In many cases these had not required any adjustment after installation, the thermostatic control on the calorifier providing sufficient regulation. In three cases thermostatic control of room temperature was provided in addition to that on the calorifier or boiler.

Average flow temperature to panel circuits was 132° F. The temperature of water returning from panel circuits was recorded in only 17 cases, but the resulting figure obtained of 105° F. is probably only slightly below the correct average figure.

The general practice has been the continuous use of the system from early autumn. Operating theatres and special cases, however, may require heat throughout the year. Without exception, warmth has been evenly distributed. In 40 cases out of 42 embedded panel systems examined the conditions were comfortable and satisfactory; in the two cases instructions regarding conditions of operation had not been followed.*

Natural ventilation was used in all panel warmed rooms excepting operating theatres, where the necessity for the rapid removal of anaesthetic fumes, etc., requires mechanical ventilation. In this case the air, introduced by a fan, is preheated in order to assist in maintaining the comparatively high temperature requirements in a theatre by replacing the heat lost in the evacuated air. Practically all types of windows have been used and the usual method of opening windows for natural ventilation in both calm and windy weather has proved quite satisfactory. In three

(Continued on page 81)

A room in the British Embassy at Washington. The coils are embedded in the ceiling.

Note the absence of radiators or any evidence of heating equipment. Decorative lines are unimpaired. The feeling is that of gentle sunshine.

—Illustrations courtesy of Wolff & Munier, U.S., licensees of Richard Crittall & Co. Ltd. of London.

(Continued from page 61)

Exempt	Taxable
	Screen door sets; Store door sets; Thumb. Lifts: Sash. Locks: Cabinet; Chest; Cupboard; Desk; Drawer; Locker; Suitcase; Trunk; Wardrobe. Lock strip. Padlocks. Plates: Door; Hinge; Kick; Letter box; Mirror; Number; Push. Pulleys: Awnings; Ceilings; Clothesline; Ventilator. Sash: Centers; Pulls; Rollers; Sockets. Sheaves: Ball bearing. Showcase Hardware of all kinds. Spindles: Closet; Knob. Stop Bead Washers; Strikes of all kinds; Transom: Catches; Chains; Eyes; Lifters; Stays. Thresholds; Turns: Cupboard; Weather strip. In addition to the foregoing all panic and fire-exit fixtures, whether locking or not, are taxable. Mortise and rim cylinders when sold separately are also taxable.

The exemption refers to the items mentioned only, and locks are construed as meaning any fastening for use on a door where a key is used.

The exemption does not extend to keys sold separately, nor to repair parts such as door handles, door pulls, door closers, door springs, nor to any other hardware items than those named.

Structural Steel to be Used Exclusively for the Framework and Support of Buildings and Bridges

Exempt	Taxable
The framework proper, together with supporting steel as for floors, cross-beams and the like for buildings and bridges; Reinforcing steel for concrete construction of buildings or bridges.	Ferry aprons or docks; Dams; Crane runways; Buckle plates; Turn tables; Towers; Stand pipes; Pipe lines; Poles; Sub-stations; Tanks; Electric furnaces; Metal furniture; Aerial tramways; Radio masts; Railway cars and equipment; Elevators; Material handling equipment; Steel cross ties for railways.

Articles and Materials to be Used in the Manufacture of the Foregoing Exempt Goods

Another exemption has been provided, effective June 17th, 1938, for:

> Articles and materials to be used or consumed exclusively in the manufacture or production of the aforementioned building materials but not to include materials consumed by waste or wear, or abrasives, lubricating oils, fuel oils, permanent or non-permanent plant equipment.

General

No refunds will be paid to unlicensed dealers for stocks of merchandise they had on hand or that were in transit to them on the morning of June 17th, 1938. No additional sales tax was collected from these dealers when the rate was increased.

The sales tax regulations provide that "Delivery of goods to a common carrier is prima facie deemed to be delivered to the buyer and the tax is payable if such delivery has been made". Therefore, if goods were delivered to a common carrier on June 16th, the sales tax is properly applicable.

The department has refused to permit purchasers to return stocks of merchandise and have it re-shipped to them without the sales tax, and holds that this is a method of evasion. Excise Tax Auditors are especially warned to watch for this.

You are asked to note that some of the building products, as for example plaster boards, fibre boards, glass for buildings, etc., are conditionally exempted for building purposes, and in such cases it will be necessary that certificates be given to suppliers certifying as to the use to which the material will be put.

Directory of Social Service Agencies in Canada Issued

A very complete compilation of the various social agencies, public and voluntary, in the different centres throughout Canada has been published by the United States Department of Justice, through its Bureau of Prisons at Washington. This is another of the many fine analyses of facilities of different types in Canada which have been prepared from time to time, either by the United States government or the national organizations of different kinds in that country. This particular study was made possible through the assistance of the District of Columbia and is a W.P.A. project. It was prepared primarily for the use of social service units, and parole offices in federal and correctional institutions. However it is available to those needing information concerning welfare agencies. This multigraphed bulletin is very exhaustive, for instance, it lists 10 organizations in Halifax, 15 in Montreal, 18 in Toronto, and 22 in Vancouver. We are not certain how extensive is the availability of this bulletin, but inquiries could be addressed to Mr. Edgar M. Gerlach, Supervisor of Social Service Bureau of Prisons, Department of Justice, Washington.

American College of Surgeons to Meet in New York, October 17-20

THE twenty-first annual hospital standardization conference will be held in conjunction with the annual convention of the American College of Surgeons, in New York, Monday to Thursday, October the 17th to 20th. The Waldorf Astoria Hotel has been selected as headquarters.

Doctor MacEachern has arranged a most interesting hospital program. Much of the discussion has been arranged in the form of panel discussions, thus giving wide scope and variety to the program.

Monday a.m., October 17

Dr. Frederic A. Besley, President of the American College of Surgeons, will review the benefits of standardization to medical science. Dr. George Crile will officially announce the list of approved hospitals and Dr. D. B. Phemister, Chairman of the Committe on Graduate Training for Surgery, will report the survey of such facilities. The remainder of the morning will be devoted to a discussion by six leading authorities on graduate training in general surgery and the specialties.

Monday p.m., October 17

There will be 6 papers dealing with such subjects as co-operation between voluntary and municipal hospitals, nursing, personal management, volunteer services and bibliotherapy. Dr. Goldwater, Miss Effie Taylor, Father Schwitalla, Dr. Joseph C. Doane and Dr. Christopher G. Parnall are among the contributors.

Tuesday a.m., October 18

The main portion of this session deals with physical and other conditions in the hosptal related to the care of the patient and the working conditions of the personnel. Lighting, air-conditioning, noise, etc., are being discussed, and Dr. Claude Munger, Mr. Charles F. Neergaard, Dr. Harvey Agnew and others will contribute. There will also be a motion picture illustrating the blood bank service at Cook County Hospital.

Tuesday p.m., October 18

The entire program for Tuesday afternoon is devoted to obstetrics, with some ten well known speakers, including Dr. M. T. MacEachern, Dr. Fred L. Adair, Dr. Paul Titus, Miss Jessie Turnbull and Dr. George W. Kosmak on the program. Subjects will range from the presentation of the minimum requirements for the obstetrical department to the palm print method of infant identification.

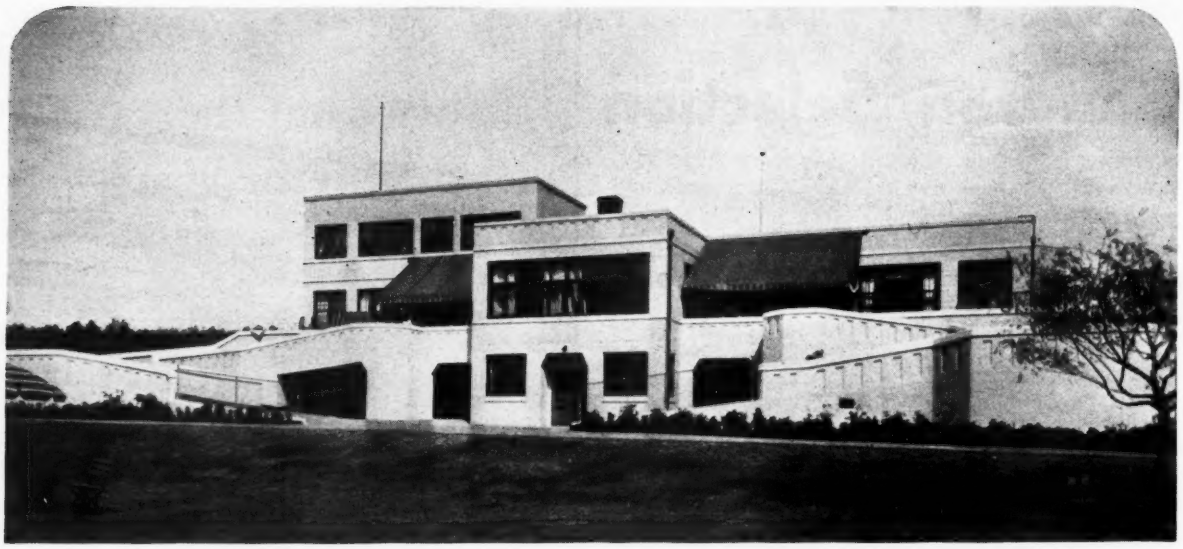
Tuesday Evening, October 18

On this occasion a joint session is being held with the Greater New York Hospita Association, the President of which is Dr. Claude W. Munger, and an excellent program is being presented. Mr. D. H. McAlpin Pyle, Doctor William H. Walsh, Mr. L. M. Arrowsmith, Mr. C. Rufus Rorem and Dr. R. C. Buerki, all of whom have been very active in hospital association work in their various fields, will speak.

Wednesday a.m., October 19

This is a joint conference with the Association of Record Librarians of North America, and the entire program, with some nine speakers, revolves around the gen-

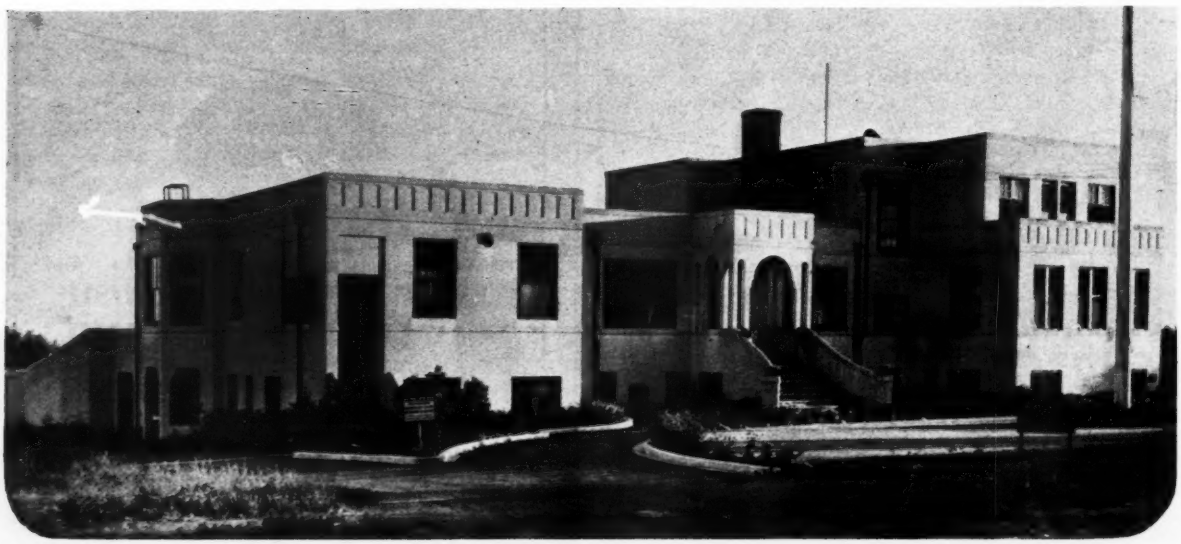
(Continued on page 69)



A Modern Crippled Children's Hospital

THE Crippled Children's Hospital at 250 West Fifty-ninth Avenue, Vancouver, is an outstanding example of the modern type of construction for pediatric hospitals of moderate size. This hospital, opened in 1923, is of reinforced concrete construction, and is completely fire-proof. Accommodation is provided for 25 patients, but the building is so designed that the addition of a second storey will practically double its capacity. Facilities for surgery and plaster work are provided. There is a very complete physiotherapy department and an excellent tiled swimming pool. In a pleasant school room the children receive tuition from a teacher of the Vancouver School Board. The out-door clinic, held every Saturday morning, is an important department of the hospital and is well attended.

One feature of the design is the extensive use of ramps, which can be seen in illustration above. Mr. John Russel is president of the board of directors and Miss Erna R. Erskine is superintendent.



American College of Surgeons to Meet in New York, October 17-20

(Continued from page 66)

eral subject of medical records. It is noted that Mr. Leonard Shaw, now of Chicago, will be on this program and that Dr. Frank E. Adair of New York, Dr. Alfred W. Adson, Miss Jennie Jones and others will contribute.

Wednesday afternoon is given over to demonstrations and discussions of various administrative and medical and nursing technical procedures in local hospitals. Among the subjects to be dealt with are anaesthesia, the chronic patient, central record room and follow-up system, clinic management, food service, nursing service and preparation of sterile and parenteral solutions. Among those conducting the demonstrations will be Dr. E. M. Bluestone, Dr. Joseph Turner, Dr. Frederick J. MacCurdy, Dr. Claude Munger and Dr. J. R. Clemmons and Miss Margaret Gillam.

Thursday a.m., October 20

Thursday morning is devoted to the training of hospital executives. Mr. James A. Hamilton's paper will be discussed from various viewpoints by Dr. Donald C. Smelzer, Mr. Gerhard Hartman, Dr. Neal N. Wood, Dr. E. M. Bluestone and others.

Thursday p.m., October 20

Thursday afternoon there will be two Round Tables. The one directed by Mr. Robert Jolly, will discuss administrative practices, hospital personnel problems, trustees, business management, food service, hospital auxiliaries, linen and laundry service, house management and the small hospital.

Dr. Buerki's Round Table will consider professional practices, the clinical laboratory, anaesthesia, pharmacy, nursing service, medical social service, physical therapy, occupational therapy and medical records.

Book Reviews

THE FOOT. By Norman C. Lake, M.D., M.S., D.Sc. (Lond.), F.R.C.S. (Eng.), Senior Surgeon and Lecturer on Surgery, Charing Cross Hospital, Surgeon, Bolingbroke Hospital, Director of Studies, London Foot Hospital, Late Senior Examiner in Surgery, University of London and External Examiner in Surgery, Victoria University, Manchester. 366 pp. $3.75. Baillière, Tindall and Cox, London, and The Macmillan Co. of Canada, Ltd., Toronto, 1938.

This helpful work has now appeared in its second edition. All of the usually encountered diseases and disabilities of the foot are described and much space is devoted to such everyday and important problems as flat feet and corns. The two divergent theories of the cause of flat feet are reviewed and the value and place of exercises and arch supports discussd. The various abnormalities are considered at length as are also gait, posture, the effect of high heels and the place of the manipulative method of treating foot abnormalities.

This volume could well be added to the medical library of the hospital and would be of value to the interns, the medical staff and the director of the training school.

AIDS TO PRACTICAL NURSING. By Marjorie Houghton, S.R.N., S.C.M., D.N. (Lond.), Sister Tutor, University College Hospital, London, Examiner to the General Nursing Council for England and Wales. With Foreword by M. L. Rosenheim, M.A., M.B., M.R.C.P., Medical Registrar, University College Hospital, London. pp. 208. $1.10. Baillière, Tindall and Cox, London. Macmillans, Toronto, 1938.

A book on practical nursing "which may well be read by medical students", this book presents the methods of nursing which are in common use in London teaching hospitals. The first half of the book deals with general basic nursing duties, the last half with particular procedures under the headings; bandages, splints, plasters, extensions; first aid; enemata; artificial feeding; baths, sponging and packs; local applications; oxygen therapy and preparation of the patient for special examinations and procedures.

* * *

BAILLIERES NURSES' COMPLETE MEDICAL DICTIONARY. Revised by Margaret E. Hitch, S.R.N., St. Bartholomew's Hospital, London, and C. F. Marshall, M.D., M.Sc., F.R.C.S., 7th edition. 472 pp. Illus. 90 cents. The Macmillan Company of Canada, Toronto, 1938.

This pocket size dictionary, after an interval of two years, has gone into its seventh edition. Some 750 new entries have been made and the illustrations increased to 185. Three new appendices, bringing the total to eighteen, have been added. This section includes appendices on the care of instruments, anaesthetic apparatus (new), dose tables, poisons and their treatment, diets, bandaging and other useful data. Although naturally limited by its size, it is a very practical and useful dictionary.

* * *

AIDS TO SURGICAL NURSING. By Katharine F. Armstrong, S.R.N., S.C.M., Editor of The "Nursing Times". Late Sister Tutor at King's College Hospital, London. With Foreword by Cecil P. G. Wakely, D.Sc., F.R.C.S. Senior Surgeon and Lecturer in Surgery, King's College Hospital, London. pp. 307. $1.10. Baillière, Tindall and Cox, London. Macmillan Company, Toronto, 1938.

Written with the view that the "success of the most skilful surgeon is entirely dependent on the reliable and conscientious work of his assistants and nurses", this small volume is a splendid reference book for the student nurse. It contains a concise outline of treatment and routine care by the nurse in surgical treatment of haemorrhage, fractures, tumours, tuberculosis, breast conditions, abdominal conditions, diseases of the rectum, the genito-urinary system and the bones and joints. There are useful chapters on infection, wounds and an appendix on X-ray and anaesthesia.

* * *

AIDS TO EMBRYOLOGY. By Richard H. Hunter, M.D., M.Ch., Ph.D., M.R.I.A. Lecturer in Anatomy, Queen's University, Belfast; Sometime Examiner in Anatomy for the Primary Fellowship of the Royal College of Surgeons in Ireland. Author of "Aids to Surgical Anatomy", "A Short History of Anatomy", etc. Third

Edition. 178 pp. $1.10. Baillière, Tindall and Cox, London. Macmillan Co. of Canada, Toronto, 1938.

This book is based on a series of lectures to medical students at Queen's University in Belfast. Therefore it is primarily designed for the medical student, for whom it has proven to be an excellent guide. It is too advanced, however, for the needs of the undergraduate nurse.

* * *

AIDS TO HYGIENE FOR NURSES. By Edith M. Funnell, S.R.N., D.N. (Lond.), Sister Tutor, Royal Sussex County Hospital, Brighton. With Foreword by Clement Muir, M.B., Ch. B., D.P.H. Senior Assistant Medical Officer, Infectious Diseases Service, London County Council. pp. 223. $1.10. Baillière, Tindall and Cox, London, Macmillan Company of Canada, Toronto, 1938.

A member of a series of handy condensed text books on a series of vital subjects, this little volume deals with topics not adequately covered in the library of the average school for nurses. Such subjects as ventilation, heating, lighting, drainage, food preservation, disinfection, hygiene of the sick-room, parasites and personal hygiene are covered concisely but with adequate and practical detail. It can be recommended.

* * *

SLEEP! *The Secret of Greater Power and Achievement.* By Ray Giles. 280 pp. Illustrated. $2.00. Bobbs Merrill Company, Indianapolis and New York (McLelland and Stewart, Ltd., Toronto), 1938.

Sometimes a treatise on a physiological subject can be better handled in semi-scientific light-veined manner by a lay writer than in the more carefully weighed words of the scientist. It is doubtful if the worst addict to insomnia could hold out against the multidinous suggestions herein offered. Such range from keeping a rowing machine under the bed or exchanging yawns with the goldfish to shooting tin rabbits with a photo-electric cell gun or joining the Quaker faith. Much of the book is made up of the formulae of people frequently in the public eye and, while many suggestions are distinctly lightweight, there are many of undoubted merit. The Fire Chief could probably verify the truth of the assertion that 40 per cent of women in New York sleep in the raw; being less hardy, or perhaps more modest, only 25 per cent of the men so economize on nighties.

* * *

BIOLOGICAL STANDARDIZATION OF THE VITAMINS. By Katharine H. Coward, D.Sc., Reader in Biochemistry, University of London, Head of the Nutrition Department, Pharmaceutical Society of Great Britain. 227 pp. $3.75. Baillère, Tindall and Cox, London, and The Macmillan Co. of Canada, Ltd., Toronto, 1938.

This work is of especial value to research workers in nutrition, to pharmaceutical workers making special preparations for therapeutic purposes and to those applying vitamin therapy to dietary products. It is not of direct practical value to the average hospital biochemist or dietitian. Part One reviews at length the technique required for the determination of the various vitamins. Part Two refers to the mathematical factors involved in the statistical treatment of analytical results. Mathematical formulae involved in the calculation of the standard deviation are applied in the instance of each vitamin.

PROGRAMME

Ontario Hospital Association Convention

(Continued from page 52)

12.30 noon—Luncheon with the Ontario Hospital Association: (See programme of Ontario Hospital Association Convention).

2.30 p.m.—General Session: "The Present Day Conception of the Value of Medical Records", Dr. M. T. MacEachern, Associate Director, American College of Surgeons.

3.00 p.m.—"Medical Records from the Point of View of the Physician", Dr. R. F. Farquharson, Medical Staff, Toronto General Hospital.

3.30 p.m.—"The Value of the Medical Record to the Intern", Dr. W. R. Feasby, Resident Physician, Toronto Western Hospital.

4.00 p.m.—"Medical Records and the Social Service Department", Miss J. M. Kniseley, R.N., Social Service Department, Toronto General Hospital.

7.30 p.m.—Executive Committee: Board Room, St. Michael's Hospital.

Wednesday, November 2nd

9.30 a.m.—General Business Session: Election of officers.

2.30 p.m.—Free to attend Ontario Hospital Association general session. (See programme of Ontario Hospital Association).

Thursday, November 3rd

10.00 a.m.—Tour of Records Departments in Toronto hospitals, St. Michael's Hospital, Toronto General Hospital, Toronto Western Hospital.

* * *

WOMEN'S HOSPITAL AIDS ASSOCIATION

Royal York Hotel, Toronto
October 31st, November 1st, 2nd, 3rd

Monday, October 31st

7.00 p.m.—Executive Meeting: Parlour "B". .
—Registration and Payment of Fees.
—General Meeting: Parlour B.

8.00 p.m.—Opening Address: The President.
—Reply on behalf of delegates, Mrs. Ruby Brown, President, Mount Sinai Women's Dental Auxiliary.
—A moment of silence in honour of departed members.
—Minutes read by Mrs. H. C. Allen, Recording Secretary.
—Treasurer's Report presented by Mrs. G. W. Houston, Treasurer.
—Announcement of Various Committees.
—Roll Call: responded to by giving report.
—Reports followed by Round Table.
—Adjourn: 10.30 p.m.

Tuesday, November 1st

Morning Session

—Registration and payment of fees.

Assemble in Parlour B, promptly at 10.45 to attend formal opening of Ontario Hospital Association Convention and tour exhibits.

12.30 noon—Ontario Hospital Association Luncheon: Speaker, Dr. Malcolm MacEachern.

Afternoon Session

2.30 p.m.—Assemble Parlour B.
—Continue Roll Call and reports.
—Committee reports.
—Election of Officers.
New Business.

4.30 p.m.—Adjourn.

Wednesday, November 2nd

Morning Session

—See Programme of Ontario Hospital Association.

* * *

Ontario Association of Hospital Social Service Workers
Thursday, November 3rd, 1938

—Parlour B.
—Chairman: Dr. B. T. McGhie, Deputy Minister of Health of the Province of Ontario.

2.30 p.m.—Address by the Chairman.
—"Value to the Hospital of Medical Social Work, from the Layman's Point of View", Mr. W. H. Lovering, Hamilton.
—"Need for Organization and Value of Hospital Social Service to the Community", Miss Charlotte Whitton, C.B.E., M.A., Executive Secretary, Canadian Welfare Council.
—Discussion.
—Business meeting.

Honoured

J. Kenneth McGregor, M.D., F.R.C.S.(C), F.A.C.S.

We congratulate Dr. J. K. McGregor, Director of the McGregor Clinic and Chief of Surgical Division A of the Hamilton General Hospital, upon his election to the Presidency of the American Association for the Study of Goitre.

Two Experiences in Air Conditioning

Cooled Operating Rooms Prove Boon to Doctor

Billings Memorial Hospital, University of Chicago Clinics, has three operating rooms on the sixth floor—each with its sterilizing, scrub-up and anaesthetizing rooms. Adjoining it is a student amphitheater seating 110 students. Already equipped with a ventilating system with air washer to supply humidity in winter, this system was converted into a complete air conditioning system two years ago—system supplies operating rooms in the forenoon and amphitheater in the afternoon with about 16 air changes per hour, at a cost of 80 cents per hour. As the refrigerating plant already had ample capacity the above cost does not include the capital charge. The supply fans supply 2100 cfm. to each operating room (about 7,980 cu. ft. in size) and exhaust fan removes 1200 fm., the excess air escaping to corridors. No air is recirculated and refrigeration load is estimated at 20 tons maximum, 15 tons average.

Air intake is provided with continuous oil type and atomizing washer nozzles 2 banks of 16 each. Water for sprays is chilled through coils in a brine tank 9′ by 100′, the brine coming from plant in basement by a 2″ line. There is a 150 gal. reservoir in the chilled water circuit—controlled by two valves, one to prevent freezing.

The cooling system is under full automatic control by use of pneumatic valves, dampers and adjustable thermostats plus manual on and off switch in each operating room.

Design provides for 55% relative humidity and 16° differential in maximum summer temperature; spring, winter and autumn temperature is 74° F. with 57% relative humidity.

Due to extreme height of ceiling (9′ 4″) air is brought down to 10′ above floor level in the outer chamber of a double walled duct and discharged laterally through a specially designed diffusing head which reduces velocity from 600 fpm. in the duct to 150 fpm. at periphery. Exhaust is removed through center of this double duct cylinder.

The 4 summer month of 1934, (before conversion) required 2,585 hours operation of the 2-30 ton, CO_2 compressors (supplying all refrigeration requirements of the hospital). After conversion the same period in 1936 increased this load by 1,370 hours. Increases in cost were CO_2 $13.50, Oil $11.07, Power $857.74, Labor $204.40, Total $1,086.71, or an average cost of 79.3 cents per operating hour. In a new installation, with interest at 6%, depreciation at 10% and insurance 1% total cost would have been $2,787 or $2.03 per operating hour. The 1,370 hours operation was due to our excessively hot summer. A normal summer would have been 1,200 hours and on this basis the cost would have been $2.25 per hour.

The above figures are based on an installation already in operation. If an entirely new plant were installed the cost would be much greater.

Symon R. Flook in Heating, Piping and Air Conditioning (Hospital Abstract Service, Chicago).

The Results of Air Conditioning a Hospital

One year ago Corey Hill Hospital, Brookline, Mass., was opened as the first completely air conditioned hospital in this country. Specifications called for a relative humidity of 30% at all times, temperature of 75° F. in sub zero weather and not more than 80° F. when outside temperature was 95° F. to 100° F. System was combined cooling by refrigeration and absorption by lithium chloride. No air is recirculated on account of odors and psychological effect, air is introduced into the room by air ejector unit and each unit includes a steam coil to permit additional heat if desirable.

Heating is under zone control, the operating room in a separate zone and wings divided into separate zones to permit control according to exposure.

During the summer of 1937 the outside temperature went as high as 99° F. with a relative humidity of 55% and as low as 62° F. with a relative humidity of 94% but the temperature of the rooms never exceeded 78° F. and the relative humidity 33%. Occupants were entirely unconscious of changes in outside weather.

Ideal humidity for most individuals is between 25 and 35%. Humidities above 35% increase the load on the heart, circulation, and respiration, not usually noticed by the normal individual but definitely detrimental to the patient with circulatory disease, particularly when relative humidity exceeds 45%.

Constancy of temperature and humidity is important to the very ill patient. What the optimum temperature and humidity are for various conditions is not yet certain. There is evidence that high temperature and humidity are beneficial to the anesthetized patient and will do much to prevent surgical shock.

Our observations on rheumatics showed definite clinical and symptomatic improvement and loss of the well known ability to predict changes in the weather.

Allergics—especially hay fever and asthma showed dramatic improvement. Removed to air conditioned bedrooms at home these patients are able to retain their improvement even when carrying on normal activities and using the air conditioned room only intermittently.

Anesthesia often precipitates an attack in an asthmatic and an air conditioned environment is helpful in these cases. Diseases of the upper respiratory tract show definite benefit from air conditioning. Sinus infection, middle ear infections, pneumonia, etc., show gratifying results that cannot be accounted for by the usual medical and hospital procedures. During hot humid days heart disease, kidney disease, high blood pressure, and other chronic conditions show definite benefit—often dramatic improvement within one or two hours.

The cost is not necessarily prohibitive and can be somewhat lessened by the use of awnings.

Air conditioning is not a panacea but is a valuable tool in our fight against disease both from a curative standpoint and from a sanitary standpoint when we consider the high air pollution percentage of large cities.

Albert G. Young, M.D., in Heating, Piping and Air Conditioning. (Hospital Abstract Service, Chicago.)

News of Hospitals and Staffs

Royal Alexandra Nurses, Edmonton, Get Eight-Hour Day

A new schedule of working hours for nurses went into effect at the Royal Alexandra Hospital, Edmonton, during September. The 8-hour day and 48-hour week, which will affect 200 nurses, will cost the hospital an additional $15,000 a year and mean the employing of 16 new nurses and about 10 other women employees.

* * *

New Unit of Bracebridge Memorial Hospital, Ont., Dedicated

The dedication service of the new unit added to the Bracebridge Memorial Hospital in memory of Dr. Peter McGibbon, took place September the 8th. His Honour, the Lieutenant-Governor of Ontario, took part in the ceremony.

* * *

Carmangay Hospital, Alberta, Becomes Municipal Institution

Carmangay Hospital at Carmangay, Alberta, recently became Little Bow municipal hospital No. 25. By a vote of ratepayers in a municipal territory which included eight townships, the hospital was taken over as a municipal institution. This step will bring cheap hospitalization to all within the territory.

* * *

Moose Jaw seeks Greater Help for Hospitals

The Moose Jaw City Council has passed a resolution asking that some corrective action be taken by the hospital association to place the financial difficulties of the hospitals and their supporting units before the senior government. The local hospital board was asked to call together representatives of hospitals in the drought area at an early date.

* * *

"Pound Day" at Kentville

At the formal opening of the new Blanchard-Fraser Memorial Hospital, at Kentville, N.S., the Women's Auxiliary held a "Pound Day" to stock the shelves and fill the cupboards of the new hospital. Visitors, met at the door by the reception committee, were gently but firmly propelled toward the open arms of the "pound committee". It must have been fun to see Mr. Top Hat and his "charmingly gowned wife" gallantly struggling with their donations of jam, flour potatoes, what have you!

* * *

Blanchard-Fraser Memorial Hospital Opened at Kentville, N.S.

The Blanchard-Fraser Memorial Hospital, Kentville, N.S., was formally opened on August the 31st. The Honourable Dr. F. R. Davis, minister of Health for Nova Scotia officiated at the ceremony.

* * *

New Wing Opened at River Glade Sanatorium, N.B.

The new wing of the Jordan Memorial Sanatorium at River Glade was officially opened on September the 19th. The addition provides accommodation for fifty-five additional patients.

Two Ontario Hospitals Benefit by Will

The Hamilton Sanatorium and the Toronto Hospital for Sick Children will benefit by the will of F. G. C. Fisher, West Flamboro, Ont., who left a life interest in the $143,853 estate to his widow, upon whose decease the residue goes to the above hospitals.

* * *

Bruce County General Hospital, Ont., Receives Bequest

Bruce County General Hospital, Ont., recently received $7,000 through the estate of a late patient, Mr. Valentine Fischer.

* * *

Saskatchewan Hospital to Close

The management of St. John's Hospital, at Rosthern, Saskatchewan, definitely decided to close the hospital on October the 1st, due to inadequate financial support. The Board of Trade has been making strong efforts to obtain sufficient support to keep the hospital open.

* * *

Blood Bank Being Considered at Saskatoon

The Saskatoon City Hospital is arranging for the establishment of a blood bank for storing blood for transfusion, similar to the one now proving so successful in Edmonton, and other centres.

* * *

Member of Saint John Hospital Board Resigns

Miles E. Agar, who for 24 years has been a member of the Board of Commissioners of the Saint John General Hospital and for the last 18 has been president, has tendered his resignation. Mr. Agar has been one of the strongest hospital supporters in the Maritimes and, during his presidency, the nurses' home and, more recently, the magnificent new hospital were constructed.

* * *

Closed Staff at Regina

A proposal to make the Regina General Hospital a closed institution is being considered by the hospital board and the medical staff. There has been some dissatisfaction over the limited control of staff appointments.

Appointments and Resignations

Mr. Leonard P. Goudy, acting general superintendent of Saskatoon City Hospital since March 20th, has been appointed to that position permanently. Mr. Goudy is taking the place rendered vacant when Mr. Leonard Shaw accepted the position of Assistant Secretary of the American Hospital Association.

Miss Myrtle McMillan, former superintendent of the Glace Bay General Hospital, Glace Bay, N.S., has accepted the superintendency of the McKellar Hospital, Fort William, Ont.

(Continued on page 78)

(Continued from preceding page)

Miss Lilian I. Uren, superintendent of Parkwood Hospital, London, Ont., for the past eleven years, has resigned.

Miss Winnifred E. Cooke, formerly a member of the teaching staff at the Montreal General Hospital, will fill the newly created position of Superintendent of Nurses at Aberdeen Hospital, New Glasgow, N.S.

* * *

Sister Zephrinus is now sister superior at St. Michael's Hospital, Toronto.

* * *

Miss Gladys A. Brandt, R.N., of Elmira, Ontario, has been appointed to succeed Mrs. S. A. Price who recently resigned as superintendent of the General and Marine Hospital, Collingwood.

* * *

Sister Mary Philippe has been appointed Sister Superior at St. Paul's Hospital, Vancouver. She was formerly Sister Superior at Olympia, Washington.

* * *

Miss Myrtle McMillan, R.N., superintendent of the Glace Bay General Hospital, has resigned.

* * *

Dr. Eric Austin, recently returned from four years' post-graduate study in medical work in England and Scotland, has been appointed Superintendent of the United Church of Canada Hospital at Hazelton, B.C.

A. W. Russell Regaining Health

Mr. A. W. Russell of the T. Eaton Co., Limited, Contract Department, has recovered from a serious illness and is now spending a few hours each day at his office. Mr. Russell's many friends in the hospital field will be glad to learn that he is now able to return to his work.

Dallas Diary

(Continued from page 42)

popularity with our American friends. At the conclusion of dinner and ceremonies the floor was cleared for dancing and the treat of the evening was provided when the new president along with Jim Hamilton took a whirl at the "big apple".

Thursday, September 29th, Temperature 102°

The House of Delegates completed their session to-day, the fourth day of what in the beginning was to have been a two day session, again indicating that the new body is filling a definite need from a legislative standpoint. The National Health Programme in the United States received considerable discussion in this body and one of its major pieces of legislation was the adoption of a resolution permitting the American Hospital Association to co-operate with the medical profession in approval or otherwise of hospital care insurance which would include payments to doctors as well as hospitals. The report of the Committee on nominations and its adoption by the House of Delegates was published this morning and the election of Dr. Fred G. Carter, Administrator of Christ's Hospital, Cincinnati, as President-Elect was popularly acclaimed. Dr. Carter has been connected with hospital administration for many years and has always taken an active part in hospital or-

ganization, especially the American Hospital Association, which he has served in many capacities since his entrance into the hospital field.

The Canadian Delegation gathered for lunch at noon to-day and Canada was represented from the far west coast to the east coast. Those at the luncheon were: Dr. and Mrs. G. Harvey Agnew, Toronto; Dr. M. T. MacEachern (Lindsay, Ont.), Chicago; Mr. Leonard Shaw (Saskatoon, Sask.), Chicago; Mr. Leonard Goudy, Saskatoon, Sask.; Mr. Gordon Freisen, Belleville, Ont.; Mr. and Mrs. Carl I. Flath, Toronto; Dr. S. R. D. Hewitt, St. John, N.B.; Mr. C. C. Gibson, Regina, Sask.; Miss Pearl Morrison, Toronto; Dr. George Stephens, Winnipeg; Mr. Graham Stephens, Winnipeg; Dr. J. C. Mackenzie, Montreal, Dr. W. S. Caldwell, Toronto; Mr. S. S. Cohen, Montreal, Mr. J. H. Roy, Montreal; Dr. and Mrs. T. W. Walker, Victoria, B.C.; Dr. T. R. Ponton (Winnipeg), Chicago.

To-night through the courtesy of Texas State Hospital Association and the Dallas Local Arrangements Committee, a real Southern Barbecue was provided. They engaged John Snider, famous throughout the south in this specialty, to prepare the feast. Oh, what a treat. What a sight to see fourteen whole steers sizzling over a charcoal fire! Along with this they entertained with a special all Cowboy Band accompanied by six ropers. This was a wonderful event which will long remain in our memories.

Friday Morning, September 30th, Temperature 100°

A general round table discussion under the direction of Dr. MacEachern and Mr. Robert Jolly marked the closing of the final session of the convention. At the conclusion of this session Dr. Agnew introduced the new officers and formally closed the convention.

Health Plan Has Enrolled 2,500 Members in Ontario

Dr. J. A. Hannah, Chief Medical Officer of the Associated Medical Services, Inc., has announced that membership now stands at twenty-five hundred. This is a co-operative, voluntary plan of contributory health insurance, whereby the members, in return for their premiums, receive general practitioner care, surgical and other specialist care, substantial payment towards hospitalization and other benefits. Physicians and hospitals are paid upon a basis of the service rendered. This organization was launched with the support of the Ontario Medical Association and the local medical societies in the centres where the plan has been organized. Membership is now increasing at the rate of about 300 a month. Since June the 1st, 1937, when the association was formed, approximately 1,400 accounts have been paid. Some 720 physicians in Toronto alone have signified their willingness to work with this new association and give their services to its members.

This experiment in the province of a broad type of health coverage, supported on a voluntary contributory basis has attracted wide interest throughout Canada and the United States. Many investigators have expressed the opinion that a co-operative voluntary plan of this type will prove to be the best solution for the economic problem of sickness as it concerns the individual of moderate means.

Construction

J. Cecil McDougall is the architect for the proposed Women's Pavilion at the Verdun Protestant (mental) Hospital, Verdun, Quebec. L. G. Ogilvie Construction Company is already building the new nurses' residence for the hospital.

* * *

Quesnel General Hospital, Quesnel, B.C., is planning a new $12,000 wing.

* * *

Plans for the nurses' residence to be erected at the Verdun Protestant Hospital, Verdun, Que., were prepared by J. Cecil McDougall, and consulting engineers for mechanical equipment are McDougall and Freedman. Cost is estimated at $200,000.

* * *

A campaign for $250,000 for the Homoeopathic Hospital of Montreal, has just closed. It is planned to use $100,000 to erect a new nurses' residence. Gratton D. Thompson is architect.

* * *

C. B. Foster is contractor of the new hospital which is to be built at Annapolis Royal, Nova Scotia.

* * *

The general contract for construction of the $200,000, 70-bed unit of the hospital being built by the Sisters of Charity of St. John in Vancouver, has gone to E. J. Ryan Contracting Co., Ltd.

* * *

Plans are being drawn up for the proposed new annex to the Sydney River mental hospitals by A. J. MacCormick, Sydney architect.

* * *

Joseph Sawyer is the architect for proposed interior alterations at Notre Dame de Lourdes Hospital, Montreal.

* * *

The addition to Mercy Hospital for Incurables, Toronto, has been abandoned and erection of a new building on another site is now considered. Pigott Construction Company, Toronto, is general contractor.

* * *

The village of Gimli, Manitoba, has been left $13,000 by the will of Bjorn Johnson, a late resident. The money is to be used for the erection and maintenance of a general hospital in the village.

* * *

The proposal that the city of Red Deer, Alberta, loan the Red Deer Municipal Hospital a sum up to $60,000 for the building of a new wing will be voted upon in the near future.

* * *

Work has commenced on the $50,000 hospital to be constructed at Ste. Rose du Lac, Manitoba, by the Grey Nuns of St. Boniface. Architects are Green, Blankstein, Russell and Ham of Winnipeg.

* * *

After the approval of the Ontario Municipal Board had been granted, the St. Thomas City Council approved the issue of debentures amounting to $51,000 for the proposed Nurses' Home there.

* * *

Construction is going ahead on the proposed $200,000 hospital at St. John's, Newfoundland. Owner is the Roman Catholic Episcopal Corporation of St. John's.

Attention Dietitians

The Canadian Dietetic Association wishes to correct the address of Miss Ethel Stibbard, councillor of the association, which was published in the August issue of The Canadian Hospital as Vancouver. Miss Stibbard is at the Jubilee Hospital, Victoria, British Columbia.

Panel Heating for Hospitals

(Continued from page 64)

cases semi-open air wards were warmed by the panel system and in each case it was quite successful.

Two hospitals (Nos. 43 and 44) are mentioned but not included because they are held up as examples of failure. However neither of these had an *embedded* installation as is now recommended. One was put in 24 years ago with surface pipes covered with magnesite flooring material. This has required a water temperature of 165° F. rather than the 120° F. now required. The other hospital did have a low temperature installation but the pipes *were not embedded;* they were clipped to the ceiling and enclosed in plaster. Composition piping was used instead of the mild steel now recommended. The result was a number of ruptures with leakage.

Benefits

In an overwhelming majority of the hospitals visited those interviewed endorsed the convenience made possible by the absence of exposed pipes and claimed an appreciable lessening of the labour of cleaning. Many of the hospitals showed a reduction in the cost of periodic redecoration, and reported that in no case had repairs to the panels been necessary (time of operation runs from 12 to 1 season). Unfortunately figures were not available for a comparison of heat consumption of the panel installation with that of other services. However, tests on office and other buildings have shown substantial savings, which it is to be expected would be duplicated in hospitals. The majority of the medical and nursing staffs and the engineers consulted consider the warmth to be pleasant, comfortable and convenient; a number of architects associated with the work were interviewed also and all were strongly in favour of low temperature invisible panel warming for hospitals.

***It is surprising how comfortable one can be at 65°F. or even in the lower 60's with radiant heat. It is stated, however, that in one hospital with an outside winter temperature of 30°F., patients were reported quite comfortable at a ward temperature of 53°F. In this country, where we are not accustomed to fireplace heating as in so many homes of Great Britain, and where our people are softened by excessively high room temperatures, further experimentation under rigorous climatic conditions would seem desirable.—(Ed.)**

Ethics and Medicine

(Continued from page 25)

other, are and must be, closely inter-related. If the spirit in both doctors and nurses is one of courtesy, understanding, appreciation, co-operation and zeal for the welfare of the people, differences should not arise, or, if they do, should be quickly adjusted."

(Continued on next page)

The Public

(Continued from preceding page)

The paragraph, Of the Duties of the Profession to the Public, breathes the very spirit of the late D. A. Stewart in its wide and kindly humanism:

> "The vision of the good physician should reach beyond the welfare and cure of humanity. The New Medicine is social as well as clinical, with new ways of distribution to the needs of the people. The New Medicine asks how the utmost possible in service can be made widely and instantly available, reaching beyond those who ask to those who need but do not ask, and to those who need yet do not know they need. Any wastage of health or life anywhere is a challenge to our profession. Our public health measures, local and general, are practical humanitarianism, influences for race improvement, as potent as the world has known. Every physician, whatever his special training, should be officially or unofficially a servant of the State for the betterment of health. It is our privilege to be preventers of disease as well as curers, statesmen and ambassadors of health, planners of new worlds, counsellors of the people of a new day."

Scattered through the Code are particularly apt quotations from the writings of Sir Thomas Browne, Francis Bacon, Ambroise Pare and Louis Pasteur. The Code has been dedicated by the Canadian Medical Association to David Alexander Stewart "who in his own life and practice translated into action the principles laid down in this Code."

Finally, the Code does not, and cannot, pronounce on all the knotty problems which may arise in the multifarious contacts between patient, physician, hospital and nurse, but it does seek to lay down general principles which will apply to all situations. Guided by it, the physician who is anxious to do right will seldom fail in his duty to his patients or to his fellows. The Code is virtually a paraphrase of "Seek ye first the kingdom of God and his righteousness; and all these things shall be added unto you." The Code can be followed with confidence. Application for copies of the full Code may be made to the General Secretary of the Canadian Medical Association, 184 College Street, Toronto 2.

Taking Hospitalization Instead of Dividends

(Continued from page 27)

origin) were not slow in accepting the plan of hospitalization on a co-operative basis. It was mutually agreed between the St. Andrew's Co-operative Society and St. Martha's Hospital that the amount of $9.00 be deducted from the profits of the shareholders annually and made over to the hospital in semi-annual payments as an insurance premium. The hospital on its part was to give free public ward service for five weeks to the insured and his dependents, free laboratory service and medicine, and 50% discount on private or semi-private rooms. This contract is renewed yearly. At the end of the last year, the hospital found that the premium did not cover the cost of hospitalization, and the shareholders willingly agreed to raise the premium to $12 per year. A single man without dependents pays $9.

The local branch of the Knights of Columbus, number-

ing eighty-one members has since adopted a similar scheme of hospitalization. The terms are the same as outlined above, and the premium is paid quarterly through the organization.

In all cases, in order to protect the hospital, special identification cards are provided with the name of the insured, and the names of his dependents on the one side, and, on the other, a list of the hospital benefits available.

Thus far the Co-operative Hospital Insurance is proving of benefit both to the insured and to the hospital. Other co-operative agencies are studying the scheme and it is believed that they will soon take advantage of it.

It would appear that Co-operative Hospital Insurance is here to stay.

Health Service to Employees at Salem Hospital

(Continued from page 30)

ated and supervised health plan for employees. Recently an applicant for position as chef was found in routine examination to have a positive Widal reaction with no history of recent previous innoculations. It is not hard to visualize the serious situation his employment in the kitchen might have precipated. A further illustration was found in the results of an initial examination of an orderly recommended by an approved registry. He had excellent references from many larger hospitals but his initial check-up showed he had a positive Wasserman. I am sure the hospital might have been open to criticism if he were accepted for employment.

One of the most important functions of this service was to direct the check-up of about 30 employees who developed a mild diarrhoea; each employee was examined and a stool specimen obtained from each person affected. Samples of milk were examined and sources of food were immediately checked. Water taken from each tap in the hospital was thoroughly tested and dysentery bacillus was obtained from a tap connected with the regular city supply. From the time it became evident that this water was contaminated and could be associated with the diarrhoea, only spring water was used in the hospital until such time as the water was proven safe for consumption. The state Board of Health was notified and a thorough investigation of the water supply was made by taking various samples from fire and police stations having a common water supply. We were never informed of the complete results, but understand that some changes were made in the vicinity of the city water supply where considerable W.P.A. construction was going on. In this case we not only safeguarded the employees and patients of the hospital but also our health plan proved a safeguard to the community.

During 1936 there were 336 visits by employees to the health physician; in 1937, 219 sought medical aid; routine complete physical examinations to new employees numbered in 1936—33, and in 1937—54. Patients requiring treatment in specialized fields are referred to members of the staff qualified to render that particular type of service.

Conclusions A Health Service for all employees should be a routine procedure in every hospital.

The Regulation of Blood Transfusion

The use of blood transfusion has become so general that a recent survey by Levine and Katzin of the conditions under which it is practised on this continent is most welcome.* This survey was carried out by means of a questionnaire sent to the leading American and Canadian hospitals, and whilst answers were received only from about half of these the information gained is impressive, and in some instances startling.

Some of the points brought out are as follows: (a) The blood group classification most widely used is that with the Moss numbering (IV, III, II, I). The international classification (O, A, B, and AB) is being used more and more, but most of the hospitals still have an arbitrary nomenclature. A plea is made for the advantages of the International method since it so clearly indicates the rationale of the grouping. It is suggested that the schools teach this method uniformly and also that the blood donor agencies make a point of using it. At present most of the hospitals affiliated with schools do not use it.

(b) The methods of giving transfusions vary widely. Less than half of the hospitals use one method only; the majority follow two methods. In 36 there are three different procedures, and in 4 all of the 4 recognized methods are used. The citrate method is the most popular, apparently because it is thought that no special precautions are needed for it. In the New York and New Jersey hospitals the Lindeman multiple syringe method is the most widely used, but some other hospitals use several varieties of instruments. Slightly less than half of the hospitals use two methods, the citrate and one of the syringe-valve procedures. There is something to be said for this choice of methods.

(c) The important question was asked: who performs the transfusions? The answer was that in the majority of hospitals the residents and interns do, under supervision either of senior residents or attending physicians. Only in a small group of hospitals, notably in New York City, is there a transfusion team in charge. In more than one-third of the hospitals transfusions are not in the hands of any one department but are done by any one of the attending staff. In several instances the everchanging house staff performs them with no supervision whatever.

(d) Donors for indigents. Blood is supplied to indigents in a little more than half of the answering hospitals. In 85 hospitals there is no provision for this free supply, and in 43 other institutions it is offered only occasionally, or in cases of most urgent need.

(e) Repetition of Wassermann, Kahn, or Kline tests on donors. Nearly half of the hospitals failed to answer the question on this point. Ninety reported that such tests are performed on donors at intervals of from one to three months. In 112 the interval is six months or more. More significant are the data regarding tests for syphilis just before transfusion. In only 178 out of 350 hospitals is this *always* done; in 36 it is done "frequently or usually"; in 26, only on volunteer donors; in 5, only on professionals; in 83 it is not done.

Other details of interest are brought out, such, for example, as the selection of donors. The importance of this might seem to need no comment, but the number of acci-

dents reported suggests negligence in the technique of grouping. The advantage is strongly emphasized of special transfusion teams in each hospital who shall instruct the interns in transfusion. Such teams might also serve to link up transfusion work between the hospitals of each city. They could regulate professional donors by proper registration, a much needed arrangement, and also serve as centres for studying problems relating to transfusion. What can be done by concentrated effort in this matter is shown in a report in the same Journal† of the Blood Transfusion Betterment Association of New York City. This Association reports extraordinary growth in activity, its work having tripled in seven years. It would be well for each large centre to follow its example. We know of one large hospital in Montreal in which an exhaustive study of the whole question of transfusion and intravenous injections has been made, but there seems to be a need for wider co-ordination. The giving of blood transfusions will inevitably and properly increase very rapidly, and the risks with which it is hedged about must receive more serious consideration.

H. E. MacDermot, M.D.,

In The Canadian Medical Association Journal.

*Blood transfusion in America, J. Am. M. Ass., 1938, 110: 1243.
†Ibid., 1938, 110: 1248.

The Soldiers' Memorial Hospital Board at Tillsonburg, Ont., has announced that a new $30,000 wing is to be added to the hospital.

The Ontario Municipal Board has granted the application of St. Thomas, Ontario, for approval of the Nurses' home by-law without a formal vote of the ratepayers.

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